Washington

UNIFORM APPLICATION
FY 2024/2025 Combined MHBGSUPTRS BG ApplicationBehavioral Health Assessment and Plan

SUBSTANCE ABUSE PREVENTION AND TREATMENT
and
COMMUNITY MENTAL HEALTH SERVICES
BLOCK GRANT

OMB - Approved 04/19/2021 - Expires 04/30/2024
(generated on 08/30/2023 2.13.52 PM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

and

Center for Mental Health Services
Division of State and Community Systems Development

State Information

State Information

Plan Year

Start Year	2024
End Year	2025

State SAPT Unique Entity Identification

Unique Entity ID	LNHZYKMNB9T5

I. State Agency to be the SAPT Grantee for the Block Grant

Agency Name	Health Care Authority
Organizational Unit	Division of Behavioral Health and Recovery
Mailing Address	PO Box 42730
City	Olympia
Zip Code	98504

II. Contact Person for the SAPT Grantee of the Block Grant

First Name	Michael
Last Name	Langer
Agency Name	Health Care Authority
Mailing Address	PO Box 42730
City	Olympia
Zip Code	98504
Telephone	360-725-9821
Fax	360-725-2280
Email Address	michael.langer@hca.wa.gov

State CMHS Unique Entity Identification

Unique Entity ID	LNHZYKMNB9T5

I. State Agency to be the CMHS Grantee for the Block Grant

Agency Name	Health Care Authority
Organizational Unit	Division of Behavioral Health and Recovery
Mailing Address	PO Box 42730
City	Olympia
Zip Code	98504

II. Contact Person for the CMHS Grantee of the Block Grant

First Name	Keri
Last Name	Waterland
Agency Name	Health Care Authority
Mailing Address	PO Box 42730
City	Olympia

Zip Code 98504-2730

Telephone 360-725-5252

Fax 360-725-2280

Email Address keri.waterland@hca.wa.gov

III. Third Party Administrator of Mental Health Services

Do you have a third party administrator? ○ Yes ◉ No

First Name

Last Name

Agency Name

Mailing Address

City

Zip Code

Telephone

Fax

Email Address

IV. State Expenditure Period (Most recent State expenditure period that is closed out)

From

To

V. Date Submitted

Submission Date 8/30/2023 2:02:44 PM

Revision Date 8/30/2023 2:04:17 PM

VI. Contact Person Responsible for Application Submission

First Name Janet

Last Name Cornell

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OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Washington

Bipartisan Safer Communities Act Work Plan for FY23-24

COMMUNITY MENTAL HEALTH SERVICES
BLOCK GRANT

Center for Mental Health Services
Division of State and Community Systems Development

Mental Health Block Grant Bipartisan Safer Communities Act (BSCA) Work Plan

WA State Summary

The COVID-19 pandemic has had a significant impact on people with Serious Mental Illness (SMI) and Serious Emotional Disturbance (SED) in Washington State. During the first half of 2019, 8.2% of adults over 18 years of age had symptoms of anxiety disorder and 6.6% had symptoms of depressive disorder. By comparison, in the most recent Household Pulse Survey from the Centers for Disease Control examining trends from February 17, 2021, to March 1, 2021, this prevalence quadrupled to 33.4% for anxiety and 27.7% for depression (in Washington state, rates were slightly higher with 34.2% for anxiety, 14th highest of the 50 states, and 27.8% for depression, 23rd highest of the 50 states). The age group with the highest prevalence rates nationally is 18–29-year-olds (47.2% reporting anxiety, and 42.2% reporting depression). The devastating impacts of the COVID-19 pandemic have clearly impacted young adults' mental health and substance use (a population already at high risk).

This is a critical time to address potential harms and to ensure our workforce is equipped to address these worsening mental health symptoms, in both adults and youth. Our mental health providers are working hard to provide treatment services to those populations most in need, diagnosed with SMI and SED.

The Washington Health Care Authority respectfully submits the proposal and budget summary you will find below. Washington is grateful to SAMHSA for the opportunity to extend the Bipartisan Safer Communities Act funds allowing us to continue expansion of mental health crisis services within our state. As you will see below, our plan is a continuation of the expansion and work we began last year using the Bipartisan Safer Communities Act funding.

Budget Table

MHBG Bipartisan Safer Communities Act Budget	**FFY24**	**FFY25**	**Total 2 Year Budget**
First Episode Psychosis CAPS Expansion	$100,000	$100,000	$200,000
Certified Crisis Intervention Specialist Training	$ 291,816	$801,905	$1,093,721
Administrative Costs	$ 20,633	$47, 457	$68,090
Total Budget	**$ 412,449**	**949,362**	**$1,361,811**

MHBG Bipartisan Safer Communities Act Project Detail

Project #: MBS2-01

Project Title: Central Assessment of Psychosis Service (CAPS) Expansion
Proposed Budget: $200,000

Scope:
A primary goal of the state's initiative to support treatment of First Episode Psychosis is to accurately identify youth and young adults earlier in the course of diagnosed psychotic illness. Doing so unequivocally supports engagement in Coordinated Specialty Care, reduces the Duration of Untreated Psychosis, and can prevent inpatient hospitalizations.

To aid in this effort, Dr. Sarah Kopelovich at the University of Washington, Department of Psychiatry & Behavioral Sciences, in coordination with New Journeys Implementation Lead Dr. Maria Monroe-DeVita, developed the Central Assessment of Psychosis Service (CAPS). Based at the University of Washington, CAPS extends specialized expertise in screening and assessment of psychosis and psychosis-risk states to the New Journeys Network, enabling teams to refer diagnostically complex referents for comprehensive psychological testing to determine (1) whether New Journeys admission criteria are met, and (2) personalized treatment recommendations.

Expanding CAPS is squarely in line with state and federal efforts to support Early and Periodic Screening, Diagnostics, and Treatment for high-risk and high-impact health conditions, a core ambition of the Bipartisan Safer Communities Act (BSCA) (P.L. 117-159) supplemental funding. A stage-wise expansion, executed in collaboration with the Health Care Authority; New Journeys Network; Washington State Center of Excellence for Early Psychosis; New Journeys evaluation partner, Washington State University; and University of Washington Medicine, is outlined below.

The activities outlined below are responsive to best practices in measurement-based care and public health campaigns, all of which are associated with a reduced Duration of Untreated Psychosis, cost savings, and evidence-based coordinated care at the population level. Furthermore, investments in CAPS using 1-time BSCA funds will enable CAPS to be implemented at all New Journeys sites, including sites that will be added to the Network in FY24 and 25. Finally, the proposed activities will support an enhanced role of the Central Assessment of Psychosis Service to serve as a centralized "front door" to all individuals referred to the New Journeys Network, thereby furthering the state's mission to enhance equitable access to mental health care by facilitating timely, culturally-sensitive, and psychometrically validated screening and assessment processes.

Describe any plans to utilize the BSCA supplemental funds to develop/enhance components of your state's mental health emergency preparedness and response plan that addresses behavioral health. Please include in your discussion how you plan to coordinate with other state and federal agencies to leverage crisis/mental health emergency related resources.

Expanding CAPS is squarely in line with state and federal efforts to support Early and Periodic Screening, Diagnostics, and Treatment for high-risk and high-impact health conditions, a core ambition of the

Bipartisan Safer Communities Act (BSCA) (P.L. 117-159) supplemental funding. It supports crisis intervention work by providing a diagnostic and referral service during the workforce shortage where there is currently pressure on the front door of the system of care and lack of staff to perform this function.

Describe any plans to utilize the BSCA supplemental funds to develop/enhance a state behavioral health team that coordinates, provides guidance, and gives direction in collaboration with state emergency management planners during a crisis.

CAPS supports crisis intervention work by providing a diagnostic and referral service during the workforce shortage where there is currently pressure on the front door of the system of care and lack of staff to perform this function. This service would support front door access decreasing the need for crisis interventions. A stage-wise expansion, executed in collaboration with the Health Care Authority; New Journeys Network; Washington State Center of Excellence for Early Psychosis; New Journeys evaluation partner, Washington State University; and University of Washington Medicine.

Describe any plans to utilize the BSCA supplemental funds to develop/enhance a multidisciplinary mobile crisis team that can be deployed 24/7, anywhere in the state rapidly to address any crisis.

It supports crisis intervention work by providing a diagnostic and referral service during the workforce shortage where there is currently pressure on the front door of the system of care and lack of staff to perform this function. Statewide equitable access is prioritized in Second Substitute Senate Bill (2SSB) 5903 (2019) and coordinates with existing resources such as the PAL line.

Describe any plans to utilize the BSCA supplemental funds to develop/enhance crisis/mental health emergency services specifically for young adults, youth and children, or their families, including those with justice involvement and having SED/serious mental illness (SMI).

Access to appropriate referral and screening diverts youth and young adults from other systems mismatched to their needs of SMI/SED.

Describe any plans to utilize the BSCA supplemental funds to develop/enhance services provided to communities that are affected by trauma and mass shootings/school violence.

A statewide public health campaign to raise awareness of psychosis risk states, the New Journeys Network, and CAPS services will provide educational resources related to psychosis in youth and young adults affected by trauma and mass shootings/school violence. The service can be a referral resource for crisis responders, professionals, families and individuals experiencing symptoms.

Describe any plans to utilize the BSCA supplemental funds to develop/enhance culturally and linguistically tailored messaging to provide information about behavioral health in a crisis/mental health emergency and/or to identify culturally/linguistically appropriate supports for diverse populations.

A public health campaign can help to raise awareness, reduce stigma and provide a path to early intervention for psychosis in youth and young adults throughout the state of Washington addressing the needs of diverse populations. The service can be a referral resource for crisis responders, professionals, families and individuals experiencing symptoms.

What other mental health emergency/crisis behavioral health practices or activities does the state plan to develop or enhance using the BSCA supplemental funds?

See proposal for Certified Crisis Intervention Specialist Collaborative Training.

Clearly describe the proposed/planned activities utilizing the funds for both FY24 and FY25 as two separate sections, including an estimated budget for each year. States will be required to report on what activities have been completed using this funding.

FFY24Proposed Activities

- Continued development of educational, marketing, and promotional material related to early psychosis treatment services in the state;
- Curate resources for appropriate care outside of New Journeys Network
- Consolidate relevant resources in accessible, navigable online location for the general help-seeking public and professionals
- Coordinate with existing University of Washington professional consultation service lines to ensure that practitioners statewide serving individuals diagnosed with SMI/SED can easily refer clients to the New Journeys Network
- Strategic visioning of the Enhanced Central Assessment of Psychosis Service, including but not limited to:
    - SWOT (Strengths, Weakness, Opportunities, and Threats) analysis with relevant stakeholders (e.g., UW Medicine, HCA, New Journeys teams);
    - institutional coordination for enhanced services (e.g., UW Compliance approvals);
    - establishing operational, clinical, and technical infrastructure;
    - aligning with comparable services within the department and/or state;
    - forecasting demand for expanded consultation and clinical services;
    - developing workflows for enhanced services
- Establish CAPS onboarding for new New Journeys sites (e.g., Site of Practice agreements, referral processes)

Proposed FFY24 Budget: $100,000

FFY25 Proposed Activities

- Contractor will hire a new junior clinical faculty with expertise in early psychosis assessment and treatment who could help us start to build out both the assessment service and the statewide resource and referral options along with partners at Seattle Children's Hospital.
- · Develop Center of excellence website be more engaging to families, to make it easier to access CAPS, New Journeys, and other resources (e.g., Psychosis REACH, NAMI), and to feature recovery stories. This would also help facilitate the work we're doing with the media campaign and creating the centralized referral pathway.
- · Continue to develop and launch statewide multimedia public health campaign
- o CAPS awareness
- o New Journeys awareness
- o Awareness of other available resources for psychosis education and treatment
- · Continue to establish operational, clinical, and technical policies and procedures to manage a centralized process for New Journeys inquiries and intakes
- · Continue programmatic data collection and monitoring
- · Continue to provide psychodiagnostic support to New Journeys teams at the referral and admissions stages

Proposed FFY25 Budget: $100,000

Project #: MBS2-02

Project Title: Certified Crisis Intervention Specialist II Collaborative Training
Proposed Budget: $1,093,721

Scope:
Crisis response is a specialized discipline requiring responders to understand brain science behind the person in crisis. Trying to de-escalate a person when the sympathetic nervous system is flooding the fight, flight, or freeze response and can result in behavior that appears like non-compliance, resulting in responders leaning more on law enforcement during these times of stress. By providing a training that is based in pathophysiological trauma responses, responders better understand what part of the brain is active and will learn the science and techniques to validate the individual, redirect in safe ways, and get the prefrontal cortex reengaged. By doing this, the person de-escalates rapidly, feels understood and can make a choice that improves the outcome.

We would like to continue to provide a statewide crisis intervention training for practitioners from several programs who regularly interact with people diagnosed with SMI and SED while in crisis. The training will be shared across domains so that people performing crisis intervention will begin to share a

common understanding of the pathophysiology of a person in crisis. This partnership will span several programs in the state for high acuity clients in crisis. The programs selected include all existing and new mobile rapid response crisis teams (MRRC), including endorsed teams, including youth, Mobile Response and Stabilization Services (MRSS) teams, community-based crisis teams, PACT teams, HOST, Designated Crisis Responders, WISe teams, New Journeys, and others identified by the Health Care Authority, all of which treat/interact with individuals diagnosed with SMI or SED.

Currently, training in crisis response lies with the behavioral health agencies, and there is not a consistent approach. The workforce has had high turnover during the Covid-19 pandemic, leaving newer staff with less training and mentorship in crisis de-escalation. By increasing the competency of behavioral health professionals in crisis response de-escalation techniques, there is less dependence on enlisting the help of law enforcement for staff safety.

A person in crisis can have behaviors that mimic noncompliance. Due to this, people in crisis are often engaging with law enforcement. This can result in higher incarceration rates and legal troubles. By training crisis responders and behavioral health agencies delivering targeted outreach, we can lessen the use of law enforcement and impacts of this on communities of color, including BIPOC and LGBTQ+ persons.

Describe any plans to utilize the BSCA supplemental funds to develop/enhance components of your state's mental health emergency preparedness and response plan that addresses behavioral health. Please include in your discussion how you plan to coordinate with other state and federal agencies to leverage crisis/mental health emergency related resources.

These funds will ensure coordination among programs already doing crisis response in the state. Crisis teams, PACT, WISe and New Journeys practitioners will use uniform techniques. We are currently providing this training across agencies doing crisis response and plan to extend this to additional providers. This training has been provided to agencies in Washington and will ensure greater partnerships in the behavioral health crisis response system.

Washington State passed engrossed second substitute house bill E2SHB 1477 in 2021 to enhance the crisis system for all as 988 went live on July 16, 2022. As part of that bill, mobile rapid response crisis teams should be ready to respond to people in crisis without law enforcement. Washington passed E2SHB 1134 in 2023, which creates a voluntary endorsement for MRRCT, endorsed teams may not include law enforcement. Washington is participating in a quality learning collaborative to expand Mobile Response and Stabilization Services (MRSS) to youth in coordination with a system of care grant with SAMHSA. This model understands the developmental needs of youth and that an in-person response without law enforcement is key.

Describe any plans to utilize the BSCA supplemental funds to develop/enhance a state behavioral health team that coordinates, provides guidance, and gives direction in collaboration with state emergency management planners during a crisis.

Current mobile rapid response crisis teams coordinate with statewide emergency management during a crisis event. We are currently training behavioral health crisis provider agencies in a nationally accredited model of de-escalation. This will ensure collaboration among agencies, programs, and 911,

988 dispatchers by starting to use common language and understanding about how people can react during a crisis event or disaster.

Describe any plans to utilize the BSCA supplemental funds to develop/enhance a multidisciplinary mobile crisis team that can be deployed 24/7, anywhere in the state rapidly to address any crisis.

These funds will ensure that mobile response teams are trained in a common trauma informed approach to respond in person and de-escalate during a crisis. The mobile crisis teams are located all over the state and are staffed to respond 24/7/365 to anyone, anywhere and anytime. WISe teams, PACT teams are responsive 24/7/365 to enrolled individuals across the state.

Describe any plans to utilize the BSCA supplemental funds to develop/enhance crisis/mental health emergency services specifically for young adults, youth and children, or their families, including those with justice involvement and having SED/serious mental illness (SMI).

By implementing nationally recognized standardized de-escalation trainings across the state, providers responding can provide developmentally appropriate de-escalation. Practitioners can coach parents during historically high stress times in their family such as transitions in foster care, getting ready for school, transitions home and bedtimes which supports justice system diversion by giving behavioral health responders and parents a tool to de-escalate before calling law enforcement. Youth with SED and SMI can present with behaviors that indicate a need, which appear as disruptive or non-compliant, causing law enforcement involvement. With effective training, parents can rely on mobile response teams and WISe teams to de-escalate. By teaching parents to understand the brain science behind escalations, MRSS teams and WISe staff can provide pscyho-education to the family to ensure trauma informed, compassionate de-escalation occurs in all settings.

Describe any plans to utilize the BSCA supplemental funds to develop/enhance services provided to communities that are affected by trauma and mass shootings/school violence.

HCA has invested in nationally recognized standardized de-escalation training, which has been provided to behavioral health providers in the state and if a mass shooting or school violence event were to occur, the programs we have identified to be trained would all be deployed in their respective regions to support those in need. The interagency response would enable emergency responders, mobile rapid response crisis teams, community based crisis teams, mobile response and stabilization (MRSS) teams, PACT teams, WISe and FEP New Journey's providers and others to provide similar proven de-escalation techniques that are compassionate, trauma informed and effective.

Describe any plans to utilize the BSCA supplemental funds to develop/enhance culturally and linguistically tailored messaging to provide information about behavioral health in a crisis/mental health emergency and/or to identify culturally/linguistically appropriate supports for diverse populations.

HCA is partnering with local tribal leadership and the Native and Strong Lifeline here in Washington in the roll out of the enhanced crisis system. As part of E2SHB 1477, the Crisis Response Improvement Strategy (CRIS) committee was formed, and they formed a steering committee and subcommittees including the Tribal subcommittee and Lived Experience subcommittee in order to embed equity in crisis

delivery statewide. E2SHB 1134 allows tribal nation crisis responders to apply to become endorsed. The CRIS vision embeds equity into the crisis system, to include developmentally, culturally/linguistically and equitable responses to people in crisis. By investing in a common curriculum for crisis de-escalation, it serves to ensure that de-escalation is based upon understanding the sympathetic fight, flight, and freeze response during a crisis event rather than any unconscious bias the responder has.

What other mental health emergency/crisis behavioral health practices or activities does the state plan to develop or enhance using the BSCA supplemental funds?

See proposal for Central Assessment of Psychosis Service expansion.

Clearly describe the proposed/planned activities utilizing the funds for both FY24 and FY25 as two separate sections, including an estimated budget for each year. States will be required to report on what activities have been completed using this funding.

HCA will procure a crisis de-escalation trainer, who is nationally recognized with a significant certification (ex. National Anger Management Association), with experience in Washington state, to provide the Certified Crisis Intervention Specialist (CCIS), Level II training, or equivalent, for up to at least 1,080 crisis staff over the course for two years. Priority will be provided to the statewide Crisis Teams. This cross-training effort includes staff from PACT teams, New Journey's teams and WISe teams. HCA is also exploring the opportunity to develop a train the trainer model for sustainability.

Total funding requested: $1,093,721

FFY24 Proposed Activities
HCA staff will procure a contractor to deliver the CCIS Level II training. Cost includes training, manual, lifetime certification in CCIS II from the National Anger Management Association and application fee for participants. The HCA contract manager will help promote the training and track the total number of participants who have completed the training.

Proposed FFY24 Budget: $291,816

FFY25 Proposed Activities
The contractor will implement the training plan to provide the CCIS Level II training to individuals from Crisis Teams, PACT teams, New Journey's teams and WISe team and others identified by HCA. HCA may work with the contractor in FY25 to develop a Train the Trainer model to help sustain training efforts across the state. The HCA contract manager will help promote the training and track the total number of participants who have completed the training.

Proposed FFY25 Budget: $801,905

SAMHSA Recommendations Utilized in Proposed MHBG BSCA Workplan Include:

Identify multidisciplinary mobile crisis team(s) that can be deployed rapidly, 24/7, throughout the state to address the mental health components during an emergency/crisis.

Provide behavioral health crisis response trainings (for e.g., therapeutic crisis intervention and de-escalation) to agencies and providers identified in the statewide plan.

Develop and provide specific, evidence-based services for those affected by mental health emergency/crisis-related trauma, including mass shootings/school violence.

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [SUPTRS]

Fiscal Year 2024

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Substance Abuse Prevention and Treatment Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Section	Title	Chapter
Title XIX, Part B, Subpart II of the Public Health Service Act		
Section 1921	Formula Grants to States	**42 USC § 300x-21**
Section 1922	Certain Allocations	**42 USC § 300x-22**
Section 1923	Intravenous Substance Abuse	**42 USC § 300x-23**
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	**42 USC § 300x-24**
Section 1925	Group Homes for Recovering Substance Abusers	**42 USC § 300x-25**
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	**42 USC § 300x-26**
Section 1927	Treatment Services for Pregnant Women	**42 USC § 300x-27**
Section 1928	Additional Agreements	**42 USC § 300x-28**
Section 1929	Submission to Secretary of Statewide Assessment of Needs	**42 USC § 300x-29**
Section 1930	Maintenance of Effort Regarding State Expenditures	**42 USC § 300x-30**
Section 1931	Restrictions on Expenditure of Grant	**42 USC § 300x-31**
Section 1932	Application for Grant; Approval of State Plan	**42 USC § 300x-32**
Section 1935	Core Data Set	**42 USC § 300x-35**
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	**42 USC § 300x-51**
Section 1942	Requirement of Reports and Audits by States	**42 USC § 300x-52**

Section 1943	Additional Requirements	**42 USC § 300x-53**
Section 1946	Prohibition Regarding Receipt of Funds	**42 USC § 300x-56**
Section 1947	Nondiscrimination	**42 USC § 300x-57**
Section 1953	Continuation of Certain Programs	**42 USC § 300x-63**
Section 1955	Services Provided by Nongovernmental Organizations	**42 USC § 300x-65**
Section 1956	Services for Individuals with Co-Occurring Disorders	**42 USC § 300x-66**

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions

to State (Clear Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
    a. Checking the Exclusion Extract located on the System for Award Management (SAM) at **http://sam.gov [sam.gov]**
    b. Collecting a certification statement similar to paragraph (a)
    c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work place in accordance with 2 CFR Part 182 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
    1. The dangers of drug abuse in the workplace;
    2. The grantee's policy of maintaining a drug-free workplace;
    3. Any available drug counseling, rehabilitation, and employee assistance programs; and
    4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
    1. Abide by the terms of the statement; and
    2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
    1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
    2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-construction Programs and other Certifications summarized above.

State: ______________________________

Name of Chief Executive Officer (CEO) or Designee: ______________________________

Signature of CEO or Designee[1]: ______________________________

Title: ______________________________ Date Signed: ______________________________

mm/dd/yyyy

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[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [SUPTRS]

Fiscal Year 2024

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Substance Abuse Prevention and Treatment Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1921	Formula Grants to States	**42 USC § 300x-21**
Section 1922	Certain Allocations	**42 USC § 300x-22**
Section 1923	Intravenous Substance Abuse	**42 USC § 300x-23**
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	**42 USC § 300x-24**
Section 1925	Group Homes for Recovering Substance Abusers	**42 USC § 300x-25**
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	**42 USC § 300x-26**
Section 1927	Treatment Services for Pregnant Women	**42 USC § 300x-27**
Section 1928	Additional Agreements	**42 USC § 300x-28**
Section 1929	Submission to Secretary of Statewide Assessment of Needs	**42 USC § 300x-29**
Section 1930	Maintenance of Effort Regarding State Expenditures	**42 USC § 300x-30**
Section 1931	Restrictions on Expenditure of Grant	**42 USC § 300x-31**
Section 1932	Application for Grant; Approval of State Plan	**42 USC § 300x-32**
Section 1935	Core Data Set	**42 USC § 300x-35**
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	**42 USC § 300x-51**
Section 1942	Requirement of Reports and Audits by States	**42 USC § 300x-52**

Section 1943	Additional Requirements	**42 USC § 300x-53**
Section 1946	Prohibition Regarding Receipt of Funds	**42 USC § 300x-56**
Section 1947	Nondiscrimination	**42 USC § 300x-57**
Section 1953	Continuation of Certain Programs	**42 USC § 300x-63**
Section 1955	Services Provided by Nongovernmental Organizations	**42 USC § 300x-65**
Section 1956	Services for Individuals with Co-Occurring Disorders	**42 USC § 300x-66**

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions

to State (Clear Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
    a. Checking the Exclusion Extract located on the System for Award Management (SAM) at **http://sam.gov [sam.gov]**
    b. Collecting a certification statement similar to paragraph (a)
    c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work place in accordance with 2 CFR Part 182 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
    1. The dangers of drug abuse in the workplace;
    2. The grantee's policy of maintaining a drug-free workplace;
    3. Any available drug counseling, rehabilitation, and employee assistance programs; and
    4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
    1. Abide by the terms of the statement; and
    2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
    1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
    2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
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The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

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The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
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4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-construction Programs and other Certifications summarized above.

State: Washington State

Name of Chief Executive Officer (CEO) or Designee: Keri L. Waterland

Signature of CEO or Designee[1]:

Title: Division of Behavorial Health and Recovery, Division Director

Date Signed: 08/17/2023

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [MH]

Fiscal Year 2024

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
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as required by
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Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
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Title XIX, Part B, Subpart II of the Public Health Service Act		
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Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
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9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to

State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
    a. Checking the Exclusion Extract located on the System for Award Management (SAM) at **http://sam.gov [sam.gov]**
    b. Collecting a certification statement similar to paragraph (a)
    c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
    1. The dangers of drug abuse in the workplace;
    2. The grantee's policy of maintaining a drug-free workplace;
    3. Any available drug counseling, rehabilitation, and employee assistance programs; and
    4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
    1. Abide by the terms of the statement; and
    2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
    1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
    2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
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I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: ____________________

Signature of CEO or Designee[1]: ____________________

Title: ____________________ Date Signed: ____________________

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Please upload your state's Bipartisan Safer Communities Act (BSCA) – 2nd allotment proposal to here in addition to other documents. You may also upload it in the attachments section of this application.

Based on the guidance issued on October 11th, 2022, please submit a proposal that includes a narrative describing how the funds will be used to help individuals with SMI/SED, along with a budget for the total amount of the second allotment. The proposal should also explain any new projects planned with the second allotment and describe ongoing projects that will continue with the second allotment. The performance period for the second allotment is from September 30th, 2023, to September 29th, 2025, and the proposal should be titled "BSCA Funding Plan 2024. The proposed plans are due to SAMHSA by September 1, 2023.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

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5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
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10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to

State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at **http://sam.gov [sam.gov]**
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Keri L. Waterland

Signature of CEO or Designee[1]:

Title: Division of Behavorial Health and Recovery, Division Director

Date Signed: 08/17/2023

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Please upload your state's Bipartisan Safer Communities Act (BSCA) – 2nd allotment proposal to here in addition to other documents. You may also upload it in the attachments section of this application.

Based on the guidance issued on October 11th, 2022, please submit a proposal that includes a narrative describing how the funds will be used to help individuals with SMI/SED, along with a budget for the total amount of the second allotment. The proposal should also explain any new projects planned with the second allotment and describe ongoing projects that will continue with the second allotment. The performance period for the second allotment is from September 30th, 2023, to September 29th, 2025, and the proposal should be titled "BSCA Funding Plan 2024. The proposed plans are due to SAMHSA by September 1, 2023.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL).
Standard Form LLL (click here)

Name

Title

Organization

Signature: Date:

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Planning Steps

Step 1: Assess the strengths and organizational capacity of the service system to address the specific populations.

Narrative Question:

Provide an overview of the state's M/SUD prevention (description of the current prevention system's attention to individuals in need of substance use primary prevention), early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. In general, the overview should reflect the MHBG and SUPTRS BG criteria detailed in "Environmental Factors and Plan" section.

Further, in support of the **Executive Order On Advancing Racial Equity and Support for Underserved Communities Through the Federal Government**, SAMHSA is committed to advancing equity for all, including people of color and others who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality. Therefore, the description should also include how these systems address the needs of underserved communities. Examples of system strengths might include long-standing interagency relationships, coordinated planning, training systems, and an active network of prevention coalitions. The lack of such strengths might be considered needs of the system, which should be discussed under Step 2. This narrative must include a discussion of the current service system's attention to the MHBG and SUPTRS BG priority populations listed above under "Populations Served."

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Washington State Health Care Authority

Washington

UNIFORM APPLICATION
FY 2024/2025 – STATE BEHAVIORAL HEALTH ASSESSMENT AND PLAN

SUBSTANCE USE PREVENTION TREATMENT AND RECOVERY SERVICES
and
COMMUNITY MENTAL HEALTH SERVICES
BLOCK GRANT

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

and

Center for Mental Health Services
Division of State and Community Systems Development

Division of Behavioral Health and Recovery
FFY24-FFY25 Block Grant Application
September 1, 2023

ASSESS THE STRENGTHS AND NEEDS OF THE BEHAVIORAL HEALTH SYSTEM

Provide an overview of the state's M/SUD prevention (description of the current prevention system's attention to individuals in need of substance use primary prevention), early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. In general, the overview should reflect the MHBG and SUPTRS BG criteria detailed in "Environmental Factors and Plan" section.

The Washington State Health Care Authority (HCA) is committed to whole-person care, integrating physical health and behavioral health services while also focusing on the social determinants of health for better results and healthier residents.

As of July 1, 2018, the Revised Code of Washington (RCW) Chapter 41.05.018 transferred the powers, duties, and functions of the Department of Social and Health Services pertaining to the behavioral health system and purchasing function of the behavioral health administration, except for oversight and management of state-run mental health institutions and licensing and certification activities, to the Washington State Health Care Authority to the extent necessary to carry out the purposes of chapter 201, Laws of 2018.

On Jan. 1, 2020, the Health Care Authority (HCA) finished a multi-year effort to integrate physical health, mental health and substance use disorder treatment services into one system for nearly 2 million Apple Health (Medicaid) clients. Integration has improved prevention and treatment of behavioral health conditions. Integration, leading to better whole person care, is working to enable many individuals to avoid commitment at the state psychiatric hospitals or divert from jails, and support them in leading healthy, productive lives. Several initiatives have been launched to improve the social determinants of health including two new Medicaid benefits that address homelessness and unemployment.

HCA integrates state and federal-funded services for substance use, mental health and problem gambling. We provide funding, training, and technical assistance to community-based providers for prevention, intervention including harm reduction strategies, treatment, and recovery support services to people in need.
With our community, state, and national partners, we are committed to providing evidence-based, cost-effective services that support the health and well-being of individuals, families, and communities in Washington State.
Our goals are to prevent substance use disorders, educate communities on mental health and support holistic, evidence-based, person-centered care that addresses both medical and behavioral health conditions.

Within HCA, the Division of Behavioral Health and Recovery (DBHR) provides a broad range of community based mental health, substance use disorder, and pathological and problem gambling services using multiple funding sources to meet the broad behavioral health needs for the citizens of our state. In addition, DBHR sponsors recovery supports and the development of system of care networks. Some of the key services DBHR provides are:

- Substance Use Disorder Prevention
- Early Intervention
- Outreach, engagement, crisis services
- Harm Reduction strategies
- Outpatient substance use disorder and mental health services
- Inpatient/residential substance use disorder and mental health services
- Mental health promotion (funded with GF-State)
- Recovery support services
- Problem gambling services

DBHR manages many funding sources that support public behavioral health services in Washington State. This includes program policy and planning, program implementation and oversight, fiscal and contract management, information technology, and decision support. In addition to these programs, DBHR contracts with the Division of Research and Data Analysis (RDA), within the Department of Social and Health Services (DSHS), to conduct comprehensive research and outcome studies.

Washington State emphasizes data driven decision-making for assessment, care coordination, and service implementation. In collaboration with DBHR, RDA has developed an innovative web-based clinical decision support application, Predictive Risk Intelligence System (PRISM). PRISM features state-of-the-art predictive modeling to support care management for individuals with lived experience with significant health and behavioral health needs. Predictive modeling uses data integration and statistical analysis to identify persons who are at risk of having high future medical expenditures or high likelihood of admission to the hospital within the next year. For instance, PRISM identifies:

- The top 5-7 percent of the Medicaid population who are expected to have the highest medical expenditures for eligibility for health home services.
- Foster youth with complex medical and behavioral health needs.
- Persons with schizophrenia and identifying gaps in their medication which could put them at increased risk of hospitalization.
- Chronic health conditions of clients who are applying for SSI.
- Health services utilization (medical, behavioral health, long-term services and supports, and long-term care) associated diagnoses, pharmacy, and assessments from both Medicaid and

- Medicare sources (for those clients eligible for both).

Washington State and DBHR strive to be in the forefront of system changes, as the following projects illustrate:

- Integrated physical and behavioral health purchasing through managed care.
- Building on a continuum of services including prevention, intervention, harm reduction treatment, crisis services and recovery support, which incorporate evidence-based programs and practices whenever possible.
- Implementation of a fee-for-service program for American Indian (AI)/Alaskan Natives (AN) for substance use disorder and mental health treatment services.
- Develop cross agency strategies for opiate substitution treatment by securing several federal grants to address the opioid crisis.
- Develop a plan, process, and structure that supports treatment and recovery for individuals who experience a substance use and mental health disorder. Individuals who experience a co-occurring disorder (COD) have one or more substance use related disorders as well as one or more mental health related disorders.
- Implementation of Secure Withdrawal Management and Stabilization Facilities.
- Implementation of two new Medicaid benefits that provide supportive housing and supported employment services to individuals most in need.
- Recovery services including but not limited to client support funds, Recovery Cafes, peer support and housing resources for individuals transitioning from inpatient settings. Supportive Housing and Supported Employment
- Intensive outpatient and partial hospitalization pilot projects
- Working with the Washington office of superintendent of public instruction (OSPI) on Project AWARE grants to behavioral health services in schools.
- Consulting on TRANSFORM (Trauma and Racism Addressed by Navigating Systemic Forms of Oppression using Resilience Methods) a holistic and culturally responsive approach to addressing levels of distress that result from traumatic experiences that includes racism.
- Center of Parent Excellence that supports parents with children and youth experiencing behavioral health with peer support, education, and supportive groups
- Youth Behavioral Health Navigators where regional teams are convening partners across the region to work on issues concerning children youth and family behavioral health, and convening multidisciplinary teams to support individual families accessing and connecting with services
- DBHR collaboratively develop the State Strategic Plan for SUD Prevention and Mental Health Promotion with 25 other state agencies and organizations. This plan captures in detail the needs and resources for Washington's Behavioral Health promotion and prevention services. Plan can be found here: https://theathenaforum.org/prevention-priorities

- DBHR funds and supports through technical assistance and training community level strategic planning that includes localized needs and resources assessment in following the Strategic Prevention Framework.
- Creation of the Indian Nation Agreement, honoring tribal sovereignty and government to government principles. This agreement accounts for the ability for the Tribe to utilized federal and grant funds to address needs in their community as they see appropriate and allowable with the parameters of any federal or state purposes. This also includes using culturally based and tribal based practices within their communities.

DBHR provides prevention, intervention, inpatient treatment, outpatient treatment, crisis services and recovery support to people who are risk for addiction or diagnosed with serious mental illness. In state fiscal year 2022:

- 43,650 clients participated in substance use disorder treatment.
- 12,516 unduplicated participants received direct services through substance use disorder prevention and mental health promotion programs and reached 7,864,400 people through population level campaigns and strategies.
- 1,690 youth received SUD outpatient treatment services.
- 197,364 adults with serious mental illness received outpatient mental health treatment services.
- 885 peers received Certified Peer Counseling (CPC) training through the Peer Support Program compared to 417 in FY20
- 530 Certified Peer Counselors registered for the 2022 Peer Pathways Annual Workforce Development Conference.
- 4,589 enrollments in Supported Employment services in SFY 2022.
- 7,338 enrollments in Supportive Housing services in SFY 2022.
- Twelve coordinated care sites were actively serving youth experiencing first episode psychosis. In SFY 2022 a total of 308 youth were served through these coordinated specialty care sites.
- HCA utilized state funds to build and sustain the workforce by creating a Housing First and Harm Reduction webinar series and a two day, in-person/virtual training sessions scheduled for June 21-22, 2023.
- 1,813 pregnant and parenting women received case management services.
- HCA began or continued Tribal pilots to implement culturally adapted programs such as New Journeys, Wrap Around with Intensive Services (WISe), Contingency Management, and more.

The Block Grants are an important driver to assist Washington State and DBHR to continue moving forward with integration of Behavioral Health and Physical Health Services. Specifically, our plan will address Substance Abuse and Mental Health Services Administration's (SAMHSA) required areas of focus, including:

Washington State Health Care Authority

-

- Comprehensive community-based services for adults who have serious mental illness, older adults with serious mental illness, children with serious emotional disorder and their families, as well as individuals who have experienced a first episode of psychosis.
- Services for persons with or at risk of substance use and/or mental health disorders with the primary focus on Intravenous drug users and pregnant and parenting women who have a substance use and/or mental health disorder.

In addition to these priority populations, Washington State's plan will address services for the following populations.

- Children, youth, adolescents, and youth-in-transition or at risk for substance use disorder and/or mental health problems.
- Those with a substance use disorder and/or mental health problem who are:
    - o Homeless or inappropriately housed
    - o Involved with the criminal justice system
    - o Living in rural or frontier areas of the state
- Members of traditionally underserved populations, including:
    - o American Indian/Alaska Native population
    - o Other Racial/ethnic minorities
    - o LGBTQIA populations
    - o Persons with disabilities

As we assess the Washington State Behavioral Health System, it is clear the complexity of the system defies a simple description. In the next few sections, Washington State's behavioral health system is described as follows:

- Contracting of the state's public behavioral health system
- Adult Behavioral Health system including addressing the opioid epidemic in Washington State
- Children and Youth Behavioral Health System
- Recovery Supports Services
- An overview of the continuum of care offered by Washington State
- Innovative Behavioral Health Strategies in Washington State

Throughout our block grant plan, we incorporate the voices of individuals with lived experience, tribes, and other system partners.

CONTRACTING OF THE PUBLIC BEHAVIORAL HEALTH SYSTEM

Public Behavioral Health System in Washington

Washington State's public behavioral health system consists of two key components: the community behavioral health system and the state psychiatric hospitals. An array of funding streams blends together to fund this entire system, including but not limited to Medicaid; general state funds; federal block grants; local/county sales tax funding; Opioid Settlement Funds, Designated Cannabis Account funds; and a variety of smaller grants from federal government agencies such as the Substance Abuse Mental Health Services Administration (SAMHSA).

Community Behavioral Health System - Overview

In 2018, the state legislature passed 2nd Engrossed Substitute House Bill 1388, transferring the responsibility for administering the public community behavioral health system from the Department of Social and Health Services (DSHS) to the Health Care Authority (HCA). This move consolidated much of the purchasing and administration for Medicaid behavioral and physical healthcare through managed care contracts with an intent to better integrate healthcare. The Division of Behavioral Health and Recovery (DBHR) transferred from DSHS to the HCA, bringing with it additional behavioral health programs, grants, and activities.

Washington completed the transformation process of moving whole-person care, integrating physical and behavioral health in January 2020. With integrated managed care, a managed care plan coordinates and pays for both physical health and behavioral health services. Washington's behavioral health system is divided into ten regions, each region has three or more Managed Care Organizations (MCO).

In addition, each region has a Behavioral Health – Administrative Service Organization (BH-ASO) to cover mental health and substance use disorder crisis services, as well as services (within available funding) for Washington state residents who are not eligible for Medicaid benefits. BH-ASOs collaborate with Medicaid managed care to ensure coordinated care for enrollees. Additionally, BH-ASO's and Tribes, hold the State-only and federal block grant contracts to provide services that are not covered by Medicaid for low-income individuals and Medicaid enrollees. The state also has a robust Indian Health Care Delivery System that includes Indian Health Services (IHS) clinics and 32 Indian Health Care Providers, and several urban Indian organizations. Funding for the Indian Health Care Delivery system, if funded by the funding sources mentioned above, along with dollars from the IHS for those Tribes with compacts from the IHS for self-determination and IHS clinics. The Federal government has directed states to pass through funds to Tribes to meet their federal trust responsibilities to AI/AN individuals to provide health care as a treaty right.

Washington's community behavioral health system offers the full continuum of care, employing strategies to

address substance use prevention and mental health promotion, offering effective mental health and substance use disorder treatment (both outpatient and residential/inpatient), and supporting recovery with a full array of recovery services and supports (peer recovery supports, supported housing and employment).

Medicaid without a managed care plan (Fee-For-Services)

Effective July 1, 2017, DBHR established a fee-for-service program for behavioral health services, specifically for individuals that do not chose to opt into managed care or have unique circumstances which do not allow them to participate in managed care. Federal law ensures that AI/AN individuals not required to opt into managed care, and HCA implemented this program to follow this law. American Indians/Alaska Natives receiving Washington Apple Health (Medicaid) coverage have the choice to receive their treatment of mental health and substance use disorder either through the managed care program or through the Apple Health fee-for-service (FFS) program. These individuals now have the freedom of choice of any behavioral health provider participating in the fee-for-service program and currently accepting patients. There are approximately 300 non-tribal providers, statewide, participating as FFS providers. If AI/AN Apple Health clients are eligible to receive care at an Indian Health Service (IHS) facility, Tribal health program, or urban Indian health program, this change does not affect their ability to receive care at those programs.

During the 2023 legislative session, the State chose to increase the FFS rates by 22% to be at parody with managed care rates. This change is intended to increase access for individuals without a managed care to needed and time sensitive behavioral health services, by building equality in the system.

State Psychiatric Hospitals

Washington has three psychiatric state hospitals: Western State Hospital, Eastern State Hospital, and the Child Study and Treatment Center. The state psychiatric facilities are operated by the Department of Social and Health Services (DSHS). The state psychiatric care system provides the following:

- Inpatient psychiatric care to adults who have been committed through the civil or criminal court system for treatment and/or competency restoration services.
- Mental health treatment services to individuals who are waiting for an evaluation or for whom the courts have ordered an out-of- custody competency evaluation.
- Evidence-based professional psychiatric, medical, habilitative, and transition services within a Recovery Care model.
- Coordination with the Behavioral Health Organizations (BHOs) or Managed Care Organizations (MCOs) to transition clients back into the community.

In addition to the two state hospitals, DSHS operates the Child Study and Treatment Center (CSTC) that provides inpatient psychiatric care and education to children ages 5 to 18 who cannot be served in less restrictive settings in the community due to their complex needs.

Other State Agencies, Tribal Governments, and Key Partners

The full continuum of care and the integration of physical health with behavioral health relies significantly on care coordination and linking with various state agencies, tribal governments, and a variety of key partners. These include but are not limited to:

- Aging and Long-Term Support Administration, Department of Social and Health Services
- Developmental Disabilities Administration, Department of Social and Health Services
- Department of Children, Youth, and Families
- Juvenile Rehabilitation, Department of Social and Health Services
- Department of Health
- Department of Corrections
- Veterans Administration
- Division of Vocational Rehabilitation
- The University of Washington Alcohol and Drug Abuse Institute
- The Office of Superintendent of Public Instruction
- Liquor and Cannabis Board
- Tribal governments and other tribal partners
- Urban Indian Health Programs (UIHP)s and urban Indian organizations

Grant Funded Programs

The Division of Behavioral Health and Recovery (DBHR) is a division within the Washington State Health Care Authority (HCA), designated as the single state authority for mental health and substance use disorder treatment. DBHR includes many grant funded services and program supports for behavioral health prevention/promotion, early intervention, treatment, and recovery support services for individuals with substance use disorder, serious mental illness, serious emotional disturbance, and/or dual diagnoses. DBHR programs and services include, but are not limited to:

- SUD Prevention
- MH Promotion
- Outreach, engagement
- Harm Reduction
- Outpatient SUD and MH services
- Inpatient/residential SUD and MH services (including voluntary and involuntary community inpatient services in community hospital psychiatric units and freestanding non-hospital evaluation and treatment facilities (E&Ts))
- Recovery support services
- Pathological and problem gambling services
- Offender Re-entry Services

- Crisis response services

SAMHSA Block Grants and other grant programs are important drivers in supporting Washington State in integrating behavioral health and physical health services.

State Tribal Agreements and Contracts with Tribes

In the fall of 2019, the Health Care Authority negotiated the Indian Nation Agreements (INA's) with Tribal governments through a consultation process. The INA is an umbrella agreement that includes the general terms and conditions and allows to include multiple scopes of work for behavioral health service as needed. This INA also includes the program agreement and scope of work for behavioral health services which includes several state and federal funding resources including the Substance Abuse Block Grant. Indian Nations can braid various funding resources to support services that best meet the needs in the Tribal communities along the spectrum of the continuum of behavioral health including mental health promotion (using state funds only), prevention, treatment, intervention, and recovery support services to support a comprehensive approach. As other federal and state resources are made available to Tribal governments, these can be added to the INA using additional scopes of work. As an example, HCA used the INA to add a scope of work to pass through the COVID SABG and MHBG funding resources made available March 2021. This also allows the Tribes the ability to focus funding on efforts that are most needed within their community that considers their needs and resources that is unique to each tribal government.

Since July 1997, DBHR has been able to provide funds to the Federally Recognized Tribes in Washington State to support the delivery of outpatient treatment services by tribal facilities and community-based prevention activities to tribal members. Each tribe receives a base of $57,499 per biennium, the remaining $1.4 million in funding is allocated to the tribes based on a methodology of 30 percent on population and 70 percent are distributed evenly between the tribes. In addition to this amount, the tribes can now access up to $50,000 of state SABG funds to support opioid response efforts. As funding resources become available, the HCA continues to identify if new funding resources can be distributed to Tribes and urban Indian organizations. For example, the HCA set aside 3% of the block grant COVID enhancement funding to provide to Tribes to implement programs through a negotiated plan as needed for their communities.

HCA plans to maintain the current level of regular Block Grant funding for Tribes and identify additional funding resources so that Indian Nations have the resources to expand their behavioral health programs as they feel is necessary for their community. Since 2020, the budget to Tribes within the INA has more than doubled, with now over seven million in funding through various resources, and more are needed.

In addition to funding provided by the DBHR block grant funds, Tribes can also contract with BH-Administrative Services Organizations.

Separate from block grant funding, the Tribes receive Medicaid reimbursement for outpatient services at the IHS encounter rate. This rate is based on tribal costs to deliver services and is negotiated every year between the Indian Health Service and the Centers for Medicare and Medicaid Services. Under 42 U.S.C. § 1396b(w)(6) and 42 C.F.R. § 433.51, the state has required local and tribal governments to provide the non-federal match for all Medicaid reimbursements for outpatient SUD treatment services. For outpatient substance use disorder treatment services provided by tribes to AI/AN clients, the federal portion is 100% - so tribes receive 100% of the IHS encounter rate for these services and there is no non-federal match. For outpatient substance use disorder treatment services provided by tribes to non-AI/AN clients, the tribe receives the federal match percentage appliable to the client (either 50% or 90%) and is responsible for the non-federal match (also known as the tribal match) using the Certified Public Expenditure attestation process. HCA offers technical assistance, training, and consultation to Tribal 638 mental health programs on billing procedures and Medicaid regulations. Additionally, the Tribes have access to 20% of the State Opioid Settlement funds.

The Health Care Authority regularly collaborates with Tribal governments and Tribal and non-Tribal Indian Health care providers on the implementation of statewide initiatives for Tribal members and for AI/AN individuals in WA state. A few examples include:

- Support for various statewide conferences as outlined in the conference and training section.
- Support for the American Indian/Alaska Native Opioid Response Workgroup.
- Support for the Tribal Centric Behavioral Health Advisory Board focused on expanding access to crisis services for AI/AN and better engagement for Tribal governments and IHCPs in service delivery for crisis and behavioral health services. Specific activities within this project include, implementation of HCA appointed Tribal Designated Crisis Responders, Washington Indian Health Coordination Hub, implementation of the Washington Indian Behavioral Health Improvement Act, ombudsman and care coordination support for complex cases, support to the maintenance of the TCBHAB with the goal of developing a Tribally operated Tribal Evaluation and Treatment facility and/or Secure Withdrawal Management facility for AI/AN individuals, development of Tribal crisis coordination protocols.
- Support for the implementation of the Community Health Aide Program, Alaska model to be implemented in Washington state, and specifically the implementation of Behavioral Health Aides. https://www.npaihb.org/chap-community-health-aide-program/
- Support to enhance and provide specific Certified Peer Counseling trainings and support for recovery coaches and recovery support services program, which is a new body of work specifically with Tribal governments.

- Support for Traditional Healing services/Traditional Indian Medicine documentation and outcome measures report.
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- Support to establish and updated data reporting system to replace the current system for SUD services called TARGET. This project aims to identify a mechanism that considers how Tribes collect date through the Indian Health Services system RPMS and various Electronic Health Records.
- Support for increase in access to behavioral health surveillance data such as the Healthy Youth Survey.
- Support to develop and adapted training materials for the Wrap Around with Intensive Services Model.
- Development of the Tribal Opioid Solutions Campaign assets, materials, technical assistance for localizations and statewide media buys for AI/AN and Tribal member audiences across the state. The HCA also partners with the Department of Health to connect this campaign to the new Tribal Suicide Prevention Campaign.gn. https://watribalopioidsolutions.com/
- The HCA maintains any government-to-government plans that have previously been developed with Tribes and urban Indian organizations around the topics of prevention, mental health, and SUD. HCA plans to expand the G2G plans to other health care areas as prioritized by Tribal governments and urban Indian organizations.

Recovery support services are an important part of the continuum of care from prevention to treatment and aftercare. Recovery support services consist of Recovery housing, recovery celebration and community recovery activities which can include: Recovery Coaching, Recovery Housing, and Recovery Care Management and Transition Services, Medication Assisted Treatment/Opiate Substitution Treatment, Purchase and Distribution of Opioid Reversal Medication (Naloxone Kit, Narcan Kit), Treatment Counseling for Non-Medicaid Individuals, Continuing Education/Training (for staff), Engagement and Screening, Recovery House Residential Treatment, Recovery Coaching and Recovery Housing, Public Awareness on Opioid Substitute Treatment (MOUD), adaptation of statewide
Tribal Treatment Media Campaign, media campaign development, Treatment Coordination, and Other opioid recovery strategies.

Primary Prevention Services

The Health Care Authority prioritizes funding for evidence-based and research-based strategies to prevent substance use disorders, while at the same time recognizing the importance of local innovation to develop programs for specific populations and emerging problems, including support for cultural activities as a prevention strategy for tribal and AI/AN communities.

Funding for direct services is primarily disseminated via:

- County contracts
- ESDs
- School districts/schools
- Community-based organization contracts
- Inter-local contracts
- Indian Nation Agreements (INA) with Washington State Federally Recognized Tribes through the Office of Tribal Affairs (OTA)

HCA uses Interlocal agreements, Vendor contracts and Professional service agreements for services such as public education campaigns, data surveillance, analytics and assessments, workforce development training and capacity building.

HCA has services and activities in all CSAP categories. Most services provided are structured evidence-based SUD prevention curriculum for youth and parenting classes for adults. Information dissemination efforts and alternative drug-free activities are permitted as part of comprehensive strategic program plans. Community and School-based services include problem identification and referral. Services also include community organizing efforts and environmental strategies that impact policy, community norms, access and availability of substances and enforcement of policies directed at substance use disorder prevention. HCA leads and engages in several statewide collaborative efforts that focus on workforce development; planning and data collection about youth and young adults; mental health promotion; and prevention of underage drinking, youth cannabis use, prescription and opioid misuse and abuse.

Washington State's Community Prevention and Wellness Initiative (CPWI) is a strategic, data-informed, community coalition model aimed at bringing together key local stakeholders in high-need communities to provide infrastructure and support to successfully coordinate, assess, plan, implement and evaluate youth substance use prevention services needed in their community. The CPWI is modeled after several evidence- and research-based coalition models that have been shown to reduce community-level youth substance use and misuse and related risk and protective factors including SAMHSA's Strategic Prevention Framework.

HCA contracts with Educational Service Districts (ESDs) for the placement of Student Assistance Professionals (SAPs) in schools as part of CPWI to provide universal, selective, and indicated prevention and intervention services using an evidence-based program, Project SUCCESS (Schools using Coordinated Community Efforts to Strengthen Students). Student Assistance Professionals (SAPs) assist students to overcome problems of substance misuse and strive to prevent the misuse of, and addiction to, alcohol and other drugs, including nicotine. The SAPs also provide problem identification and referral strategies through referrals to behavioral health providers and support students in their transition back to school after they receive treatment.

Tribes have the discretion to use currently allocated SABG prevention funds to support school-based prevention and intervention services. Funds support staff time in a middle and/or high school to provide both prevention and intervention services.

HCA has also recently secured a replacement system of the current Management Information System which will support prevention services and captures each subcontractor's prevention plan and monitors their progress and impact. Funds will support enhancements to the reporting system that the current system does not currently capture.

HCA has implemented many meaningful workforce development strategies with the assistance of SABG funds that have been made available to SUD professionals both in the field as well as at HCA. These programs include the Substance Abuse Prevention Specialist Training (SAPST), hosted each year by HCA. HCA partners with numerous agencies to host trainings such as the Prevention Ethics Training, whose hours can be credited towards the Prevention Specialist Certification (CPP) which is validated by the Prevention Specialist Certification Board of Washington. All trainings that are offered to providers and contracts in the field are posted to a site, which is supported through block grant funds and serves as a communication conduct with providers and contractors.

DBHR and the Office of Tribal Affairs work with Tribes and Urban Indian Organizations to provide primary prevention and mental health promotion services that include meaningful engagement in traditional and cultural programs as well as information dissemination strategies. HCA supported the delivery of a Native American SAPTS training for prevention professionals working with tribal and urban Indian communities across the state.

ADULT BEHAVIORAL HEALTH SYSTEM

Mental Health

Since the transition to fully integrated managed care, five managed care organizations (MCOs) contract with the Health Care Authority to provide a complete array of physical and behavioral health services to enrolled individuals with Medicaid. The list of possible services includes brief intervention, crisis services, family treatment, freestanding evaluation and treatment, individual and group treatment, high intensity treatment, medication management and monitoring, peer support, rehabilitation case management, mental health

treatment in a residential setting, and stabilization services. In addition to these services, individuals may also receive the mental health services they formerly received via the MCOs prior to integration, such as those provided by clinicians in private practice or via primary care settings. Indian Health Care Plans also provide these services through MCO and Fee for Service payment models.

The MCOs contract with provider groups and community behavioral health agencies. Individuals may choose which MCO they wish to enroll with, and each region has a minimum of three plans responsible for serving the geographical region.

Each region has one Behavioral Health Administrative Service Organization (BH-ASO) responsible for administering the Involuntary Treatment Act (ITA) and the crisis response system for all people in their service area. Crisis services are available to all residents of the state, without regard to funding or Medicaid eligibility. Tribal governments may also choose a designated crisis responder to perform ITA investigations that can be designated by the HCA.

In most communities, crisis and involuntary services are highly integrated. Crisis services include a 24-hour crisis line and in-person evaluations for those presenting with mental health crises. Crises are to be resolved in the least restrictive manner and should include family and significant others as appropriate and at the request of the individual. Washington will be substantially expanding mobile crisis outreach services including child/youth teams on a statewide basis. Recent legislation passed will improve availability of crisis relief centers, mobile crisis, and community-based crisis intervention services in the state with a goal of response times almost on par with other first responders. Washington is also integrating commercial payors into the crisis system to streamline access and improve availability of crisis services. ITA services include in-person investigation of the need for involuntary inpatient care. A person must meet legal criteria and refused or failed to accept less restrictive alternatives to be involuntarily detained.

Voluntary and involuntary community inpatient services for adults are provided in community hospital psychiatric units and in freestanding Evaluation and Treatment facilities (E&Ts) authorized by the MCOs and BH-ASOs or billed directly to the state for individuals without a managed care plan. In addition to community-based mental health services administered by HCA, DSHS's BHA also operates two state psychiatric hospitals serving adults who are civilly committed under RCW 71.05, committed under RCW 10.77 who are court-ordered criminal defendants needing competency and restoration services, or individuals found by a court to be "not guilty by reason of insanity". Jail and community-based competency evaluations are also offered locally. The Governor has directed that these hospitals are to transition to Centers for Forensic Excellence and that civil commitments shall be treated within community-based settings, community hospitals and Evaluation

and Treatment facilities. This transition is underway currently, however additional beds and resources are still required in the community for it to be completed. Hospital liaisons from the MCOs (and BH-ASOs for non-Medicaid populations) assist with to transition individuals back into the community.

Substance Use Disorder Treatment

Managed Care Organizations (MCOs) and Behavioral Health Administrative Service Organizations (BH-ASOs), through contracts with community substance use disorder agencies, provide a complete array of quality

treatment services to youth and adults with substance use disorders. Access to substance use disorder outpatient treatment services is initiated through an assessment at a local outpatient or residential facility. The American Society of Addiction Medicine (ASAM) level of care determines medically necessary services as well as where to provide the services. Treatment plans are based on the results of the assessment, are individualized and designed to maximize the probability of recovery.

Both Managed Care organizations and BH-ASO's contract with provider groups and community substance use disorder agencies. Each BH-ASO and FIMC region serve all Medicaid enrollees within its geographical area except for a portion of the American Indian Alaskan Native (AI/AN) population who have opted out of receiving SUD services through the Managed Care Plans and instead have opted to receive services through the fee-for-service delivery system.

Residential and Outpatient Treatment

Intensive residential and outpatient treatment for substance use disorder includes counseling services, medication, case management, life skills, education around SUD, and, in some cases, co-occurring mental health and SUD treatment. Some patients receive only outpatient or intensive outpatient treatment. Other patients transfer to outpatient treatment after completing intensive residential services. Relapse prevention strategies remain a primary focus of counseling. There are currently three types of residential substance use disorder treatment settings for adults in the state:

- Intensive inpatient treatment provides a concentrated program of individual and group counseling, education, and activities for people with SUD and their families. There are currently 58 intensive inpatient residential providers with a total capacity of 1,893 beds. The BHOs may subcontract for intensive inpatient services. Each patient participating in this level of substance use disorder treatment receives a minimum of 20 hours of treatment services each week.
- Long-term residential treatment provides treatment for the chronically impaired adult with impaired self-maintenance capabilities. There are currently 21 adult long-term residential providers with a total capacity of 505 beds. Each patient participating in this level of substance use disorder treatment receives a minimum of four hours of treatment per week.

- Recovery Houses provide personal care and treatment, with social, vocational, and recreational activities to aid with patient adjustment to abstinence, as well as job training, employment, or other community activities. There are currently five adult recovery house providers with a capacity of 58 beds statewide. Each patient participating in this level of substance use disorder treatment receives a minimum of five hours of treatment services per week.

Persons who Use Drugs (PWUD)

Syringe Services Programs (SSP)

Syringe Services Programs (SSP) are community-based public health programs that provide critical services in non-judgmental environments to people who use drugs. Services include sterile injecting supplies and safe disposal, and access to case management, wound care, overdose reversal medication, healthcare, treatment, and support to address immediate needs. The SSP is an important component of a comprehensive set of programs designed to provide compassionate, holistic support to persons who use drugs, while also reducing the spread of HIV and other infectious disease among people who use drugs, their families and communities.

Syringe services programs (SSPs) are community-based prevention programs that provide critical services in nonjudgmental environments to people who use syringes. Services include:

- Sterile supplies
- Safe syringe disposal (PDF)
- Access to healthcare, treatment, and support.
- Syringe service programs are community-based prevention programs that can provide a range of services, including:
    - Overdose prevention education & naloxone access
    - Access to new syringes and injection equipment
    - Disposal of used syringes
    - Vaccination
    - Screening and linkage to care and treatment for infectious diseases like hepatitis C and HIV
    - Wound care
    - Health education, referrals, and linkage to health care and substance use disorder treatment

SSP's improve health outcomes and prevent disease transmission by shortening the length of time a syringe is in circulation and reducing syringe sharing. They assist in facilitate engagement of people who inject drugs in

ongoing services, such as testing for HIV and HCV, linkage to health and social services, overdose education and access to naloxone, and referral to drug treatment programs.

Medications for Opioid Use Disorder

Medications for Opioid Use Disorder (MOUD) is offered throughout Washington State through an expanding network of providers. Treatment modalities include Hub and Spoke (H&S), Opioid Treatment Networks (OTNs), Nurse Care Managers (NCMs), Office Based Opioid Treatment (OBOT) and Opioid Treatment Programs (OTPs).

Hub and Spoke (H&S) networks were started with federal funding (STR grant) and established treatment

networks in both urban and rural settings. H&S networks support collaborative, tiered levels of psychosocial and medical care to address opioid use disorder (OUD). The networks provide coordinated care within geographic regions led by a *Hub* agency that is supported by five or more contracted behavioral health treatment, primary care, wrap-around, or referral agencies (*Spokes*).

Opioid Treatment Networks (OTNs), a second-generation H&S, are designed to enhance the capacity of organizations to initiate MOUD and ensure referrals to community providers. They are more flexible than H&S in that spokes can be SUD providers, MH providers, jails, syringe exchange programs, emergency departments, etc. OTNs were designed to meet people "where they are at" in a low barrier setting to help reduce risk of overdose. Current OTNs are located across the state in jails, emergency departments, syringe service programs, shelters, and a fire department. Currently, all OTNs are funded through the SAMHSA SOR grant.

Opioid Treatment Programs (OTPs) use medication assisted treatment (MOUD)—the use of medicines—combined with counseling and behavioral therapies to treat patients with OUD. Three FDA-approved OUD medications can be dispensed from an OTP: methadone, buprenorphine, and naltrexone. All OTPs operate under the oversight of the Substance Abuse and Mental Health Services Administration (SAMHSA) and certification is overseen by WA State Department of Health (DOH).

Withdrawal Management

Withdrawal management (also known Detoxification) services are provided to help people safely withdraw from the physical effects of psychoactive substances. The need for withdrawal management services is determined by a patient assessment using the ASAM criteria. There are three levels of withdrawal management facilities recognized in Washington State. Assessment of severity, medical complications, and specific drug or alcohol withdrawal risk determines the level of service needed:

- Sub-acute Detox can be done on an outpatient basis or can be clinically managed residential facilities that have limited medical coverage. Depending on the substance that was being used and the overall health of the individual helps to determine the correct level of care. Staff and counselors monitor patients, and any treatment medications are self-administered.
- Acute Detox are medically monitored inpatient programs that have medical coverage by nurses and physicians who are on-call 24/7 for consultation. They have “standing orders” and available medications to help with withdrawal symptoms. They are not hospitals but have referral relationships with them.
- Acute Hospital Detox is medically managed intensive inpatient that have medical coverage by registered nurses and nurses with doctors available 24/7. There is full access to medical acute care including the intensive care unit if needed. Doctors, nurses, and counselors work as a part of an interdisciplinary team who medically manage the care of the patient. This level of care is considered

  hospital care and is not part of the behavioral health benefits provided through the BHOs or MCOs.

Tuberculosis Screening

Tuberculosis screening, testing and education is provided to individuals receiving SABG funded SUD treatment. The services must include tuberculosis counseling, testing and provide for or refer individuals with tuberculosis for appropriate medical evaluation and treatment. When an individual is denied admission to the tuberculosis program because of the lack of capacity, the provider will refer the individual to another provider of tuberculosis services. The provider must conduct case management activities to ensure the individual receives tuberculosis services.

CHILDREN AND YOUTH BEHAVIORAL HEALTH SYSTEM

The state has established many protocols to ensure individualized care planning for children and youth with serious mental, substance use, and co-occurring disorders, including:

- Implementation of Wraparound with Intensive Services (WISe) emphasizes a wraparound approach to both high-level and other level need youth cases, adopting the Child and
- Adolescent Needs and Strengths (CANS) assessment tool to evaluate needs and strengths in multiple domains for young people in the WISe program.
- Washington State’s First Episode Psychosis Initiative called New Journeys, placing emphasis on early intervention services for individuals experiencing early onset symptoms of schizophrenia.
- Family Peer Partner and Youth Peer Partner development in services and system development.

- System of care guiding principles are:
    - Family driven
    - Individualized, strengths based, and evidence formed
    - Youth guided
    - Culturally and linguistically competent
    - Provided in the least restrictive environment
    - Community based
    - Accessible
    - Collaborative and coordinated across an interagency network

The state has established collaborations with other child and youth serving agencies in the state to address behavioral health needs as evidenced by the Children's Behavioral Health Governance Structure. Washington has implemented Family, Youth, and System Partner Round Tables (FYSPRTs) in each of its 10 regions. These convenings include Tribal representative, youth and family with lived experience in the children's behavioral health system, and representatives from these six youth-serving state partners: Rehabilitation Administration-Juvenile Rehabilitation (RA), Department of Health (DOH), Department of Children Youth and Families (DCYF), Health Care Authority (HCA), Office of Superintendent of Public Instruction (OSPI), and Developmental Disabilities Administration (DDA).

The state had coordinated cross systems contracts for regional FYSPRTS, Children's Long Term Inpatient Program (CLIP), Wraparound with Intensive Services (WISe), and New Journeys (First Episode Psychosis Program). These collaborations have made it possible to establish partnerships to advance Mobile Response and Stabilization Services and establish a Youth and Adolescent Housing Response Team that convenes 4 state agencies to support multi-system involved youth and young adults experiencing housing instability.

Block Grant Funding has been used for several years to provide 'no cost' training and follow-up coaching to clinicians in Cognitive Behavioral Therapy Plus (CBT+). The dollars continue to support this work while in tandem developing a train-the-trainer model with the intention of placing local trainers in each Region to further grow the workforce.

Contractors will promote the use of evidence-based medicine, evidence-based practice, research-based practice, and evidence-based health care (collectively "EDPs"). The intention is steadily increasing the percentage of EBPP services for children, youth, and young people across the state.

Monitoring and tracking service utilization, costs, and outcomes for children and youth with mental, substance use, and co-occurring disorders are performed through many different methods. These include:

- Tracking evidence-based practice (EBP) reporting, and multiple input methods for WISe system rollout and CANs progress tracking.
- Following through the payment system (ProviderOne).
- Using performance-based contracting and contract monitoring.
- Monitoring Children's Behavioral Health Measures.

Washington State has identified various liaisons to assist schools in assuring identified children are connected with available mental health and/or substance use treatment, and recovery support services. All of these programs have been developed in coordination with the Washington State Office of Superintendent of Public Instruction (OSPI).

Mental Health Services

In effort to increase support for physicians to increase screening for mental health conditions, a Partnership Access Line was implemented through partnership with the University of Washington that provides child

physiatrist consultation via phone to medical providers to consult in caring for the children and youth they serve. Based on the success of this resource, a call line has been implemented for parents to call for questions, resources, and support. This access support line went live in January 2019 and is also in partnership with the University of Washington.

Washington has also implemented a Centralized Assessment of Psychosis Service (CAPS) to increase access to comprehensive psychological testing, including assessment pf psychosis risk states, for Washingtonians presenting with early signs of and symptoms of psychosis. This supports individuals in identifying and connecting to the appropriate individualized treatment.

Treatment

In addition to traditional residential and outpatient services, work continues to pilot identification and treatment through partnerships with local juvenile justice, Educational School Districts, Office of Public School Instruction, and the Office of Homeless Youth in the Department of Commerce.

Mental Health Assessment for Young Children

Within the child and youth population in Washington state, young children (birth – age 5) have the highest rates of unmet mental health care needs (HCA, 2022). Research suggests that challenges around reimbursement systems and specialty training are key barriers to access (Perigee Fund, 2021).
In SFY22-23, Washington engaged in several efforts to improve access to care for young children and their families, through specific work around developmentally appropriate mental health assessment and diagnosis, including:

- Revised reimbursement policies to adequately fund assessments best practices, including assessments that take multiple sessions and/or take place in home and community settings (i.e., natural environments). An evaluation of the impact of these reimbursement changes on service delivery will be conducted in SFY24-25.
- Free training in the DC:0-5, the developmentally appropriate diagnostic manual for young children's mental health, which is recommended by both CMS and SAMHSA. Training will continue through SFY24-25.
- Additional tools and resources to support the use of the DC:0-5, including a community-informed DC:0-5 crosswalk, and updated administrative code to allow the use of the DC:0-5 in individual service records. Additional tools and resources will be developed through SFY24-25.

Washington's innovations in this area have been featured in several national publications and conferences, but we know there is still more work to do. Our recent report highlighted the positive impacts of these policy changes, but also areas where challenges remain. In SFY24-25, we will conduct Listening Sessions with providers from each region of the state to better understand challenges and needs, which will inform our

ongoing work in this area.

AN OVERVIEW OF THE CONTINUUM OF CARE

DBHR includes services and program support for behavioral health, prevention/promotion, and early intervention, outreach/engagement, harm reduction, crisis services, treatment, and recovery support services for individuals with substance use disorder,
serious mental illness, serious emotional disturbance, and/or dual diagnoses.

Prevention/Mental Health Promotion

DBHR uses a risk and protective factor framework as the cornerstone of all prevention program investments. Our prevention programs provide outreach to segments of the population at risk for drug and alcohol misuse and abuse, with a special focus on youth who have not yet begun to use or who are still experimenting with drugs or alcohol. The implementation and delivery of these prevention programs also extend to emerging behavioral health needs through regular evaluation of surveillance data and reports (e.g., recent data suggest the need to focus on problems with marijuana and perception of harm; another report indicates a doubled risk of suicidal thoughts among boys in military families relative to their peers).

Intervention

Washington has had success with an implementation of the Screening and Brief Intervention grant.
The original Washington State SBIRT project (WASBIRT) found that providing SBIRT services in

hospital emergency departments were associated with reductions in medical costs of $366 per member per month for Medicaid patients (Estee, et al., 2010). There have also been some tribal medical staff who have become SBIRT certified.

Mental Health Treatment

DBHR funds the behavioral health care plans to provide an integrated public mental health treatment system for persons experiencing mental illness who are enrolled in Medicaid and meet the statutory need definitions for those experiencing a mental health crisis and for those who are deemed a danger to themselves or others due to a mental disorder. To meet the medical necessity criteria, a person must have a diagnosis and the requested service is reasonably expected to improve, stabilize, or prevent deterioration of functioning resulting from the presence of a mental illness.

Several Evidence-based Practice pilots tested in the state include Multi-systemic Therapy (MST), Wraparound and Multi-dimensional Treatment Foster Care (MDTFC), and Trauma-focused Cognitive Behavioral Therapy (TF-CBT).

Crisis Services

Mental Health Crisis Services stabilize the person in crisis, prevent further deterioration, and provide immediate treatment and intervention in a location best suited to meet the needs of the individual and in the least restrictive environment available. This may include services provided through crisis lines.

DBHR awarded the Seattle Crisis Clinic a performance-based contract to operate a behavioral health recovery helpline. The Washington Recovery Helpline offers 24-hour emotional support and referrals to local treatment services for residents with substance use, problem gambling, and mental health disorders. The Crisis Clinic also operates Teen Link, a teen-answered help line, each evening.

When it appears that an individual meets criterion for involuntary treatment due to a mental health disorder they are referred to a Designated Mental Health Professional, if it appears that they meet criteria for involuntary treatment due to a substance use disorder they can be referred to a Designated Chemical Dependency Specialist, for evaluation (depending on the level of acuity of the individual, and the resources available in their region). If the Designated Mental Health Professional determines that the individual meets criteria for detention under RCW 71.05, they complete a petition for detention and cause the individual to be detained to a certified involuntary psychiatric facility. If the Designated Chemical Dependency Specialist determines that the individual meets criteria for commitment under RCW 70.96A, they complete a petition for commitment and file it with court, which will issue an order for involuntary treatment in a certified substance use treatment facility.

Effective April 1, 2018, Designated Mental Health Professionals became Designated Crisis Responders and have the authority to detain individuals due to mental health disorder or a substance use disorder under RCW 71.05. Individuals detained due to a substance use disorder will be detained to a secure detoxification facility.

If an AI/AN who is served by a tribal behavioral health provider is in crisis, DBHR requires that the BH-ASOs coordinate with the tribal behavioral health provider to provide continuing services during and after the crisis. This is contingent upon the AI/AN client signing a release of information. Tribal governments are working diligently to expand and enhance their crisis services within their communities. This includes crisis response teams, tribal designated crisis responders, and tribal codes for involuntary treatment.

Substance Use Disorder (SUD) Treatment

Substance use disorder, co-occurring assessments use the American Society of Addiction Medicine (ASAM) criteria to help determine and match the individual to the appropriate level of care, and services that meet their needs. Depending upon medical necessity and individual need, outpatient, residential, or withdrawal management and stabilization can be the first entry point when receiving behavioral health services. All SUD, co-occurring providers are licensed and certified treatment agencies by the Department of Health (DOH),

whether services are provided to individuals in their local community or in another region. If an individual meets criterion for residential substance use disorder, co-occurring treatment, a referral is made, and the clinician will help assist the individual in the process of being admitted to a residential treatment facility within the state. DBHR is a recipient of The Healthy Transitions Project and System of Care Expansion grants. The Healthy Transitions Project is designed to improve emotional and behavioral health functioning for transition-age youth (TAY) age 16-25. The individual must reside within the catchment area and have been diagnosed with serious emotional disturbance (SED) or serious mental illness (SMI) including those experiencing a co-occurring disorder. This program aims to develop non-traditional recovery support services and engage TAY that might otherwise not access services. The System of Care Expansion grant provides day support services, therapeutic foster care services, support to expand youth and family networks, and to provide social marketing for mental health promotion with identified key partners.

Family SUD Navigators

The substance use disorder (SUD) family navigator project focuses on implementing navigators statewide who can serve families and individuals of loved ones experiencing SUD, of all ages, to include training, certification, licensed supervision, and development of expertise in serving family members of youth and young adults with SUD in a community-based setting. This work included the development of curriculum to educate SUD family navigators and family members on impacts of substances on the brain, potential responses, and other information to support system navigation and family wellness. DBHR has partnered with a parent run

organization to provide these trainings. Each is trained by a family member with lived experience with the support of a clinician.

Collegiate Recovery Program

Block grant funding is used to develop Collegiate Recovery Support services statewide, for a Harm Reduction Approach that combines training on best practices, technical and program development assistance for individual's Institution of Higher Education (IHEs), development of campus/community recovery capital, and facilitated network development to advance skills, share resources, and build sustainable connections. The goal of Collegiate Recovery Support is to offer the chance for students in recovery from substance use to experience the opportunities that higher education offers both in the college environment, and after by providing support, preventing a return to substance use, and promoting successful academic performance. Funding supports a network of programs that include technical and community colleges, private institutions, and 4-year universities. IHEs can receive technical assistance and tailor services to the needs of their specific institution.

Pregnant Individuals and Individuals with Children

Pregnant and Parenting Individuals (PPI) is a priority population. The services for this population are designed to meet the needs of pregnant and parenting women who are seeking services. These services include PPI

Substance Use Disorder Outpatient Treatment Services, PPI Substance Use Disorder Residential Treatment Services, PPI Housing Support Services, Therapeutic Intervention for Children, parenting education and family support services with Parent Trust for Washington Children, intensive case management services with the Parent-Child Assistance Program (PCAP), and the Washington State Fetal Alcohol Syndrome Diagnostic and Prevention Network (WA FASDPN).

Pregnant and Parenting Individuals with Children

A 16-bed Substance Use Disorder Residential Treatment Facility in Grays Harbor County, Washington implementing a Family Preservation Model will serve Pregnant, Parenting, and Partnered Parents. Children will reside in the facility with their parent(s) while their parent(s) receive treatment services.

The integrated model of care will include therapeutic interventions to treat the whole family system. Care coordination along the treatment continuum will include certified peer counselors, case management, and transitional housing support.

The model offers educational opportunities in parenting, counseling, and an onsite licensed childcare center. The model is designed to treat diverse family systems providing culturally attuned, trauma informed services. The model provides pathways for infant and parent dyads to transition into treatment upon safe

hospital discharge after birth, when an indication for Substance Use Disorder Treatment, is identified. The model provides strategic partnership the Department of Children, Youth, and Families (DCYF) both State and Tribal Liaison, for safety planning and reunification support, for child-welfare involved caregivers.

Pathological and Problem Gambling

DBHR is responsible for planning, implementing, and overseeing the Pathological and Problem Gambling Treatment program. The problem gambling program is funded through a state tax on gaming. This program includes an advisory committee that oversees prevention and treatment services. Services include educating the public on how to identify problem and pathological gambling, and how to obtain outpatient treatment services for themselves or members of their family. The program assists individuals with gambling cessation, reducing family disruption and related financial problems, and helping prevent the neglect, bankruptcies, and social costs of problem gambling. Problem gambling treatment mitigates the effects of problem gambling on families and helps them to remain not only economically self-sufficient, but to reduce their need for financial assistance from other state programs.

Office of Recovery Partnership

The Office of Consumer Partnership (OCP) changed its name in 2020 to the Office of Recovery Partnership (ORP) to better reflect the specific purpose of this office. The office currently consists of one full time staff member. The ORP is a priority within HCA with a clearly defined purpose. Some key elements include:

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- Advocates for the inclusion of behavioral health community voice and choice at every level of state government.
- Advocating on behalf of those who have lived/living experience with or who have been impacted by behavioral health challenges.
- Serves as a conduit for those who have lived/living experience with or who have been impacted by behavioral health challenges to work collectively to shape, inform and transform behavioral health systems in Washington State.
- Facilitates ORP Steering Committee comprised of lived/living experienced members from all regions of Washington state representing individuals, families, caregivers, providers, local and state government.
- Facilitates agency wide recovery and wellness employee resource group that provides support, education and resources for agency staff.
- Provides statewide behavioral health education, resourcing, advocacy and leadership training across lifespan.
- Provides oversite for statewide behavioral health lived/living experienced speaker bureau.
- Assists in the development and support of emerging community leadership.
- Promotes wellness and recovery values agency and statewide.
- Provides community outreach and engagement opportunities agency and statewide.

- Engages in the legislative process by providing guidance and review of legislation that effect behavioral health communities.

WORKFORCE DEVELOPMENT

Tribal Behavioral Health Conferences, Workforce Development and Trainings

HCA provides support to several tribal and AI/AN specific trainings and conferences. In the past biennium, HCA has offered financial support for the following conferences and trainings.

- Wrap-Around with Intensive Services (WISe) curriculum training adaptation for Tribal communities – 2023. Technical assistance to support the first Tribal WISe program coming online summer, 2023.
- Training for all new Designated Crisis Responders (DCRs) attending the DCR Academy and Trueblood program implementation staff on government-to-government principle's, the Indian health care delivery system, and best practices for working with Tribes and AI/AN communities, 2022 & 2023.
- Tribal Certified Peer Counselor trainings (2)2023.
- CPC curriculum and testing materials review for cultural attunement and provide recommendations, crosswalk, of WA State CPC curriculum compared to others including culturally based peer training curriculums, using a tribal lense.

- Contracted with WSU to provide technical assistance and work in collaboration with Tribes to develop a culturally adapted:
  - First Episode Psychosis - considerations and materials, building off of the New Journeys model.
  - Contingency Management Program for all substance use disorders, building off of promising outcomes published by WSU.
- Support for a State and Tribal delegation to learn more about the prevention program, Planet Youth Icelandic model to identify best practices that can be implemented in Tribal communities. 2023
- Support for a Tribal-State Opioid/Fentanyl Summit to convene tribal leaders and state elected officials to create solutions to address the fentanyl crisis for AI/AN individuals, families, and communities, convened on May 22-23, 2023.
- Creating of training materials that the Indian Behavioral Health Hub will use to train all 988 crisis line staff and behavioral health aides on the VOA IBHH and Native and Strong Lifeline (Tribal 988) resources and best practices to working with Tribal communities. Creation of training materials for IBHH staff and families on the Joel's Law petitions.
- Training on the prevention management information system, Minerva, 2023.

HCA is partnering with Tribes, the Northwest Portland Area Indian Health Board, Indian Health Services, and the American Indian Health Commission to work on realizing a new provider type to Washington State, called the Behavioral Health Aides. Behavioral Health Aides are federally licensed by the Indian Health Services and can provide a variety of services including mental health and SUD treatment services, prevention, and crisis response support under the supervision of a licensed clinical professional. The HCA is looking to explore ways that BHA services can be fully funded by various funding streams such as by grants and Medicaid billing. In 2022 and 2023, HCA has been working with these partners to create a State Plan Amendment to incorporate BHAs in the Medicaid State Plan. Tribal Consultation was held, early 2023 and discussion on final language is ongoing. We anticipate this will be submitted to CMS in 2023.

Co-Occurring Disorder Conference

The annual Washington State Co-Occurring Disorder (COD) and Treatment Conference for 2022 was a hybrid event, held on October 10th and 11th. A total of 446 individuals attended the event (270 registered for the virtual track and 176 registered for the in-person track).

The 2022 conference provided attendees (including consumer and family) with information regarding current legislation related to behavioral health care and services, current resources, new and emerging trends, diversity, equity and inclusion, treatment methodologies, burnout and self-care, and peer support. There were three preconference trainings: law and ethics, suicide prevention, and advanced clinical supervision skills.

The 2023 conference is scheduled for October 16th and 17th and will be an in-person event. This will be the first fully in-person COD Conference since 2019. The theme of the 2023 COD Conference is “Stronger Together” and aims to focus on reconnection and community after a long period of remote work and virtual conference experiences. The COD conference will have 4 plenary speakers focused on topics such as vicarious trauma and self-care, stories of hope and inspiration related to behavioral health challenges, diversity, equity and inclusion, and new and emerging trends in the behavioral health field. In addition to the plenary focus areas, the conference will have workshops addressing, Trauma, Medication Assisted Therapies, youth and gender issues, special populations, peer support, new facility types, and leadership and process improvement. The conference also provides opportunities for participants to network with other service providers, state representatives, other families, and individuals with COD.

Behavioral Health Conference

The Behavioral Health Conference is a two-day statewide behavioral health care conference with some all-day preconference workshops presented by the Washington Council for Behavioral Health (WCBH) and supported by the federal block grant.

The 2022 Conference theme was "Surviving and Thriving in a Changing World" and was held virtually June 15-17, 2022. A total of 590 participants registered for the conference; this number includes 73 consumers and consumer/advocates who received registration scholarships. The conference consisted of 35 workshops, as well as four keynote addresses by national speakers. In addition, a pre-conference training session entitled Washington State Law & Ethics for Behavioral Health Professionals was held virtually, in two separate sessions, on Monday, June 6 and Tuesday, June 7. Among the workshop offerings at the WBHC, there were tracks on Corrections & Mental Health, Recovery & Resiliency, Housing & Housing Support Services, Emerging, Best & Promising Practices, Race & Equity in Behavioral Health, and two general Services & Partnerships tracks.

The 2023 Conference theme was "Reconnect and Recharge!" and was an in-person event held June 14-16, 2023, in Kennewick, Washington. This was the first in person Behavioral Health Conference since 2019. The event highlighted 35 workshops, with tracks focusing on recovery & resiliency, race and equity in behavioral health, children, youth & families, corrections & mental health, services and partnerships, and more. The 2023 WBHC keynote speakers were:

- Nii Addy, PhD, a neuroscientist, Yale professor, and mental health advocate, who addressed racial disparities in mental health
- Maia Szalavitz, an expert on harm reduction with personal experience in this area
- Nathaniel Morris, MD, a psychiatrist with expertise on mass incarceration and mental illness

Say It Out Loud Conference

The Say It Out Loud (SIOL) Conference is planned in partnership with Two-Spirit, Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual (2SLGBTQIA+) communities, experts in the behavioral health field, as well as other state agencies including Aging and Long-Term Support Administration (ALTSA), Dept. of Children, Youth and Families (DCYF), Juvenile Rehabilitation (JR) etc. This conference brings together professionals from diverse fields of human services, mental health, substance use disorder treatment, substance abuse prevention, physical healthcare etc. as well as young people, parents and caregivers. Participants network, gain skills and education to improve the health and well-being of 2SLGBTQIA+ individuals, families and communities. The Division of Behavioral Health and Recovery (DBHR), Health Care Authority (HCA) has a long-standing record and recognizes the importance of partnering with communities, community providers, and state agencies to better support and care for 2SLGBTQIA+ individuals.

The 22nd annual SIOL conference was held Monday May 22, 2023, at the Davenport Grand in Spokane, WA. There were approximately 365 participants from around the state of Washington. The theme was "Let's Get Reel: Showcasing the realities and experiences of 2SLGBTQIA+ individuals from a personal perspective as well as addressing needs and inequities through effective approaches and whole person care. Let's not shy away from topics, rather elevate them to promote change." The Keynote, Roo Ramos (they/them) is an Iñupiaq,

Two Spirit liberation and equity consultant and nonprofit leader with over 20 years' experience in the nonprofit sector and in advocacy, activism, and systems change work. Roo spent much of their career advocating for Indigenous children, youth, and families in the school, justice, healthcare, and foster care system.

Each year, experts share the latest research, best practices and information with conference attendees, having one mission, and that is to improve behavioral health services, and whole person care. Workshops offered this year focused on youth, adults and older adults with topics including but not limited to: Keeping It "Reel": Media Impact Campaigns For LGBTQ+ Health Initiatives, LGBTQ+ older adults: Who will help care for us without judgment? Harm Reduction 101: Drugs and How to be Safe, Supporting LGBTQIA+ Young People in Systems of Care. We also have the privilege of providing naloxone in each participant bag. We will be providing a naloxone administration demonstration for all attendees. We want to reduce stigma and normalize carrying naloxone.

Community providers and agencies throughout the state will also attend as exhibitors to share information and resources.

Prevention Summit and Youth Forum

The annual Washington State Prevention Summit (Summit) is an enriching training and networking opportunity for youth, volunteers, and professionals engaged in health promotion and the prevention of substance misuse, violence, and other high-risk behaviors, in a setting that promotes cultural humility. The

Summit provides high-quality workshops, forums, and hands-on learning opportunities designed to meet a variety of needs, including professional development for prevention professionals. Specifically, the Summit provides education and training to prevent alcohol, tobacco, cannabis, and opioid misuse. The goals of the Summit are to increase knowledge of prevention science and practice, raise awareness of state issues, and promote the need for continued prevention work by professionals and youth. The Summit also features a track tailored to youth in ages 12 through 18. The youth track gives youth volunteers their own space to increase skills in self-development, peer relationships, drug refusal skills and strategies to strengthen personal commitment against substance use, share experiences, network, and gain knowledge to be effective leaders, prevention advocates and explore how they can be catalysts for meaningful community-level change.

HCA hosted the 2022 Prevention Summit virtually on November 9 and 10 with the theme of “Advancing Prevention: Connection and Hope”. This year we had brought the youth track back and this brought in a total of 138 youth attendees. Alongside the youth, there were a total of 372 adult attendees. In 2022, we were able to host six (6) keynotes, two (2) specifically for youth, two (2) specifically for adults and two (2) specifically for both adults and youth. For the youth track, Nigel Wrangham hosted a keynote on the Strategic Prevention

Framework and how youth can apply it to their projects in their communities and Albert Gay shared with youth the foundations of Prevention and empowering youth that when learning Prevention, they are creating a path to healthy living. In addition, we hosted youth workshops around how youth can address stress and learn healthy coping skills and the potential cross risks between gaming and substance use and how youth can build healthy gaming habits that can also lead to overall healthy habits. On the adult track, we invited Dr. Alfgier Kristjansson to share with us his work and the foundation of the Icelandic Prevention Model and brought in Dr. Jonathan Caulkins to share with us the Cannabis market trends and what we as Preventionists can prepare to do to respond to the ever-changing market. This year, we also had the privilege of working with SAMHSA's Center of Substance Abuse Prevention (CSAP) to invite both the outgoing CSAP Director, CAPT. Jeffrey Coady and incoming CSAP director, CAPT. Jennifer Fan, to host an Adult Power Session. Both CAPT. Coady and CAPT. Fan were able to speak to the CSAP's initiatives to the current challenges we are facing in the behavioral health field today and engage in an engaging Q&A session with our attendees.

We are currently planning for the 2023 Prevention Summit to take place on October 24 and 25 in Spokane, Washington. Currently, we are exploring the idea of hybrid, therefore allowing for folks to join in-person but also have some capability of virtual. We have been convening our planning committee since February 2023 and most of our planning has been around finalizing our theme and graphic. We have been working with our team's internal Graphic Designer to create a graphic to match our finalized theme of "Leading Prevention Together". As we continue to meet with our Planning Committee, we will begin planning around how our agenda will be for the next year along with beginning our Speaker Proposal process to begin submissions for interested speakers.

The Spring Youth Forum is a follow-up conference to the Prevention Summit. The Forum provides youth prevention teams the opportunity to learn from others while showcasing their own education and planning skills. Youth Teams share successes and lessons learned from projects commenced during or following the previous Prevention Summits or other youth trainings. The Prevention Summit and the Spring Youth Forum work in tandem to create momentum and help to encourage, reward and support youth-led prevention work in communities throughout Washington.

After being virtual since 2020, this year's Spring Youth Forum returned to in-person with approximately 300 participants in attendance and marking the 15th anniversary of the conference. The Forum took place on May 10, 2023, at the Great Wolf Lodge Conference Center in Grand Mound, Washington. This year's Forum awarded 40 youth team scholarships to youth leaders across the state who implemented prevention projects. As part of our programming, we hosted a showcase of Youth Prevention Projects, a Youth Town Hall, a keynote presentation on the topic of prescription misuse and opioid prevention and five (5) 60-minute youth development workshops. The youth development workshops covered topic areas related to underage drinking & cannabis prevention, mental health promotion, impaired driving, youth problem gambling prevention and

youth leadership development. We have also introduced an Adult-only workshop around engaging youth in prevention efforts using best practices.

Peer Support Training

Increase Peer Workforce

Since 2005, Washington State's Peer Support Program has been training individuals with lived experience in mental health recovery to become Certified Peer Counselors (CPCs). In 2019, in addition to training peers with mental health recovery, the Peer Support Program began training people who solely identify as having lived experience with substance use recovery as peer services were added to the substance use disorder treatment (SUD) section of the state plan. Besides the core duties of training and certifying peer counselors, the program also provides continuing education to certified peer counselors, holds an annual workforce development conference, and provides technical support for agencies who currently have peer programs or want to start a peer program.

Peer support is provided in every region of the state. What started as a small program managed by one person, has now developed into a robust training program with four full time staff. The growth of the program continues to require us to be strategic about the training and certification program. The Peer Support Program has developed a database for peer support training including an online application. This database has allowed us to increase our efficiency and better serve the behavioral health workforce needs. We are now working to expand our data collection from the database to a visual dashboard to measure trends in applications, demographics of peers and training outcomes. This dashboard will allow the Peer Support Team

and HCA leadership access to real-time data to anticipate future training needs and increase communication to external stakeholders.

The peer support program is invested in growing a cadre of approved Certified Peer Counselor trainers and approved training organizations in Washington State. The Peer Support Program has created a process utilizing a mentoring toolkit. The toolkit includes core competencies for training and a system for coaching CPCs with two years' experience providing direct peer services to become CPC training mentees. The mentees are mentored and vetted by experienced CPC trainers. The Peer Support Program continues to provide quarterly Train the Trainer events to ensure that Washington's CPC trainers have the skills they need to provide high quality trainings. The Peer Support Program is in process of creating fidelity tools for both CPC Trainings as well as CPC programs.

Since 2005, the Peer Support Program has certified 7,134 Certified Peer Counselors. The Peer support program has 95 trainings scheduled and anticipates training a total of 1,250 CPCs in SFY 2023. In FY22, 885 people

were trained as Certified Peer Counselors. Of the 970 trained so far in SFY23, 529 identify as either having substance use or co-occurring recovery have become Certified Peer Counselors. HCA anticipates using a combination of block grant and state dollars to fund a minimum of 90 trainings in SFY24.

With the passing of SSB5555 Certified Peer Specialists, HCA will be enhancing the current 40-hour curriculum to 80 hours. This work will involve collaboration with the Peer Support Advisory Group, providers, and individuals with lived experience to ensure a robust curriculum that is peer centered. This new curriculum will be in line with the new National Model Standards for Peer Support Certification. HCA has also been tasked to create a supervisor training for certified peer counselors and will begin that work in FY24. This new legislation creates a standalone licensure for Peer Specialists through the Department of Health, currently peer specialists are credentialed under the umbrella of agency affiliated counselors. This new licensure will create three different levels, a peer specialist trainee, a certified peer specialist, and a peer specialist supervisor.

Peer Support Advisory Group

DBHR values the expertise of individuals with lived experience to provide input on the future of the Peer Support Program. The Peer Support Advisory group is comprised of a diverse group of people with lived experience who have knowledge of Certified Peer Counselor training and testing, curriculum development, and who are leaders in the peer community. This group meets on a regular basis to provide feedback on program guidelines, curriculum development, trainer development, and training and testing needs.

Update Curriculum and Training

In 2019, “The Bridge” training was created to certify peers who have been trained in the CCAR Recovery Coach Model in order to meet CMS requirements for the peer services under the Medicaid State Plan. This training

allows people who are currently recovery coaches to utilize their knowledge gained in the CCAR training to take a shortened version of the CPC training, it bridges the gap. This training is a shortened version of the standard curriculum that addresses the components that are not covered in the CCAR training. These topics include documentation, ethics, boundaries, sharing your story as a peer counselor, and includes the appropriate skills checks. HCA currently sponsors this training at a minimum of four times a year. HCA is in process of updating the Certified Peer Counselor Standard training curriculum to make it more culturally diverse. These updates are done in collaboration with the Peer Support Advisory Group.

HCA is partnering with Tribes, the Northwest Portland Area Indian Health Board, Indian Health Services, and the American Indian Health Commission to work on realizing a new provider type to Washington State, called the Behavioral Health Aides. Behavioral Health Aides are federally licensed by the Indian Health Services and can provide a variety of services including mental health and SUD treatment services, prevention, and crisis response support under the supervision of a licensed clinical professional.

The Peer Support Program continues to provide continuing education opportunities for Certified Peer Counselors. HCA has the following continuing education trainings available to all CPCs made available online: The Power of Peer Support in Crisis Services, The Intersection of Behavioral Health and the Law, Enhancing Your Cultural Intelligence, An Orientation to WRAP, Certified Peer Counselor Pre-requisite training, Documenting Peer Support, Ethics and Boundaries in Peer Services, The Role Employment Plays in Recovery, and the Role Housing Plays in Recovery. HCA is in process of creating an online LMS training on Mental Health Advanced Directives and will be added to the HCA Peer Support Program website fall of 2023.

Through legislative direction in 2021, HCA developed a 40-hour in person Crisis Training for Certified Peer Counselors who work in crisis settings. This training will be required for all CPCs who work in crisis services. HCA piloted two trainings and has trained a diverse cadre of trainers to facilitate these trainings. The training will be made available to all CPCs beginning July 1, 2023, with priority given to CPCs who work in crisis settings.

In addition to the online trainings, HCA utilized COVID enhancement funds to bolster the peer workforce by providing in person continuing education opportunities. Those trainings included Intentional Peer Support and Wellness Coach Trainings.

Technical Assistance to Agencies

A technical assistance program was created called Operationalizing Peer Support (OPS). OPS provides evidence based technical and professional assistance to agencies with the implementation and operationalization of new and existing peer services. The program supports agencies and organizations through trainings, monthly webinars, and weekly “Office Hours.” Training topics include; Peer Services in Washinton state, training and

credentialling, creating a recovery orientated and trauma informed environment, licensing as a behavioral health agency and Medicaid reimbursement, recruitment, onboarding, retention of peers. peer oriented supervision, documentation, and ethics and boundaries. Operationalizing Peer Support is funded through both MHBG and SABG and is offered at no cost to agencies.

Additional Workforce Continuing Education and Technical Assistance

In 2023, DBHR held the 7th Annual Peer Pathways Workforce Development Conference. Due to COVID-19 the conference continued in virtual format and was a great success. There were 530 people who registered for the conference. We are currently planning the 8th Annual Peer Pathways Conference that will be held in person as the public health emergency has ended. Conference presenters include National and Local Peer experts with lived experience in Mental Health and Substance Use Recovery. The conference continues to grow, and we are expecting even a larger number of peers to register this year.

In 2021, the Office of Tribal Affairs in partnership with the Peer Support program provided technical assistance for tribes to become approved training entities. In addition to the technical assistance, funding was also used to provide two tribal specific trainings and two tribal specific train the trainer events through September of 2021. These events were and will continue to be used to support tribes in becoming approved training entities. HCA is partnering with the Office of Tribal Affairs to in efforts to adapt the current standard CPC curriculum to better meet the needs of Tribal and Urban Indian individuals and organizations.

COVID-19 Response

When COVID-19 physical distancing requirements were put into place in March of 2020, the Peer Support Program in partnership with our contracted training and testing organizations were able to transition our 40-hour in person training/testing to an interactive virtual training/testing within six weeks. This quick transition helped to keep our certification program on track to meet the needs of the community.

COVID-19 has challenged DBHR, our contracted trainers/testing organizations, and our other approved training organizations to be flexible. This has been a period of growth allowing us to see the value of virtual trainings. Although, in person trainings have been our training gold standard, virtual trainings have made it possible for people in rural and frontier areas, people with childcare needs, and those who are currently working to become certified peer counselors.

DBHR has transitioned back to in person trainings for the bulk of our events, however DBHR continues to offer our certification trainings in a virtual format throughout the year. This allows for individuals who live in rural or frontier areas or have personal or professional commitments that limit their ability to attend in person trainings, access to become a Certified Peer Counselor.

INNOVATIVE BEHAVIORAL HEALTH STRATEGIES IN WASHINGTON STATE

Addressing the Opioid Crisis

The Governor published an Executive Order in October 2016 to take steps to address the opioid crisis. The state developed guidelines to help health care providers treat pain and launch a Statewide Opioid Plan. In addition, the state has secured new SAMHSA grants to assist with these efforts:

Opioid Settlement Funds

Washington State is currently receiving opioid settlement funds from a variety of opioid settlements. Each of these settlements have payment structures that include distributions to the state and to local

governments. Some of these settlements will pay out over 17 years or more. The Washington State Legislature retains appropriation authority over state opioid settlement dollars. Local opioid settlement dollars are managed by individual local governments in large population areas, and by groups of local governments in rural areas that have joined together. All local governments are required to report on their use of funds through locally organized Opioid Abatement Councils.

Washington State identified the State Opioid and Overdose Response Plan as the collaborative framework where consensus recommendations on the use of opioid settlement dollars would be developed and submitted for consideration by the Governor's Office.

During the 2023 Regular Session and the 2023 Special Session, the Legislature appropriated over $80 million dollars of opioid settlement dollars for the 2023-2025 biennium. These uses include activities across the continuum including prevention, treatment, recovery support services, harm reduction services and drug user health. Following a formal consultation with Tribes, approximately $15.5 million dollars was distributed directly to Tribes for uses as decided upon themselves.

The Health Care Authority, Department of Health, and other state agencies that lead on the State Opioid and Overdose Response Plan have taken note of lessons learned during the cycle of recommendation development for the use of opioid settlement funds. The State Opioid and Overdose Response Plan will be updated during the next biennium to include those lessons learned; to adjust the plan such that it can be more effective in driving opioid related health care policy; separate out an annually updated workplan that describes funding for opioid related activities; development of a SOORP performance report that includes opioid related public health surveillance data and information on outcomes related to opioid expenditures; and a plan for community engagements, in particular engagement with BIPOC communities.

The Washington State Opioid Response Grant II (SOR II)
September 30, 2020, through September 29, 2022.

SOR II: Washington State Allocation: $27,173,792 per year/Two-year grant. Total contracts: $25,884,193

- Prevention $5,157,375
- Data $56,467
- Treatment $15,221,375
- Recovery Support Services $5,062,184

Prevention—$5,157,375

1. **Community Prevention and Wellness Initiative (CPWI) Expansion (**SOR II $3,514,927) – P1 (opioid response plan strategy 1.1) P1

Description: Fund 40 current high-need communities with the greatest risk for youth opioid and stimulant use. CPWI communities use SAMHSA's Strategic Prevention Framework (SPF) for planning, implementation, and sustainability of the coalition and evidence-based programs. Each CPWI site receives a full-time Student Assistance Professional (SAP) through local Education Service Districts (ESD) who provides school-based prevention and intervention services. The Department of Social & Health Services, Research and Data Analysis (RDA) will create community data books to facilitate local needs assessments and strategic planning. DBHR partners with WA State University (WSU) for the expansion of the Fellowship Program for 10-12 entry-level prevention professionals, building community capacity for local sites to implement CPWI and begin the strategic planning process of the SPF. Funds will also support up to seven capacity-building grants for new high-need communities in WA to conduct a local strategic planning process, including a needs and resources assessment, gap analysis, and community organizing.

Fellowship Program

Description: DBHR has contracted with Washington State University (WSU) to manage and co-develop the Washington State Fellowship Program. The 10-month Fellowship Program goals are to increase the prevention workforce for Washington State by providing Fellows with prevention system experience at both the state and community level.0 and build capacity within high-needs communities to implement prevention services. Each Cohort will spend 3 months with DBHR in Olympia, WA gaining intensive state-level prevention experience, then will spend 3 months mentoring and shadowing with an existing CPWI site, and then spend the last 4 months of their Fellowship with a new high-needs community beginning the CPWI Strategic Prevention Framework model.

2. **Community Enhancement Grants (**SOR II $452,638) – P2 (opioid response plan strategy 1.5)

Description: Prevent opioid use disorder by funding 13 community-based organizations serving 39 high-need communities. Activities include direct evidence-based prevention services, information dissemination, and environmental strategies including the promotion of secure disposal and safe home storage of opioids.

3. **Starts with One Public Education Campaign** (SOR II $908,184) – P3 (opioid response plan strategy 1.4)

Description: DBHR will contract with Desautal Hege to enhance, implement, and evaluate the statewide Starts with One public education campaign. This includes hands-on tools for community prevention providers, content on never sharing prescription medication and how to have a conversation with a friend/peer about the dangers of opioids. Campaign messaging may also expand to include the prevention of stimulants (such as Adderall and Ritalin) among youth and young adults.

4. **UW** TelePain **– (**SOR II $41,000) **–** P4

Description: Provide partial funding to the University of WA for a weekly TelePain program for access to a multidisciplinary panel of experts who provide didactic teaching and case consultation to primary care providers to reduce overdose-related deaths by improving the knowledge and prescribing practices of primary care providers.

5. **WSU Contracted Services** (SOR II $125,000) – P5 – This is combined with T7.

6. **Opioid Summit –** (SOR II $97,709) – P6

Description: DBHR is currently planning the Region 10 Opioid Summit to provide education and open dialogue with state, tribal, behavioral health, medical providers, and community providers to reduce opioid use disorder. The Summit will be held in partnership with Idaho, Alaska, and Oregon. There will be a specific component to include interventions such as naloxone, harm reduction, and other topics that support the continuum of prevention, treatment, and recovery. DBHR is currently putting together a broader planning group and individual subgroups for the coordination of breakout sessions and speakers. We will also ensure that populations such as rural communities, criminal justice, and tribal communities have representation within presentations and/or panels.

7. **Workforce Development Enhancements (**SOR II $20,000**) –** P7

Description: Enhance funding for the annual 2022 WA State Prevention Summit to increase professional development opportunities for youth and prevention professionals through opioid prevention workshops. Contract with University of Nevada Reno for conference logistics.

8. **Analysis of Evidence Based Practice (EBP) Project –** (SOR II $35,000) P8

Description: Contract to update the evidence-based program registry and outline of allowable EBPs for dissemination to the prevention field. Includes costs for updates to the technology and website needs on the Athena Forum ($5000) through WA-Tech, as well as a contract with the Washington State Institute on Public Policy, Washington State University, PIRE, or Rodney Wambeam out of the University of Wyoming.

Data -- $443,220

1. (D1) Community prevention evaluation (SOR II $20,000)**:** Contract with WA State University (WSU) to develop and disseminate community and state level reports for ongoing CPWI Evaluation. Contract may include collection, synthesis, and/or reporting of data in various formats.

2. (D2) Substance Use Disorder and Mental Health Promotion Online Reporting System (Minerva) (SOR II $20,000)**:** Support the development and maintenance of the system to track local data on prevention services, feeding into the overall evaluation of community prevention services.

3. (D3) Research & Data Analysis Division: Contract with RDA for project evaluator, programmer analyst, and GPRA coordination services for data evaluation.

Treatment—$15,221,375

1. **Opioid Treatment Networks** – ($7,098,765**)** – T1 (opioid response plan strategy 2.2)
DBHR has contracted with 15 organizations (consisting of 7 emergency departments, 5 jails, 1 syringe exchanges, 1 shelter, and 1 fire department) to create Opioid Treatment Networks (OTNs) to provide: medication for individuals experiencing opioid use disorder (OUD); funding to build OTN infrastructure; funding for staff; funding for OUD medications; and facilitation to transition individuals to community providers. Initiation sites are the funding recipients and contract holders – distribution of funding to OTNs was prioritized based on data of highest need and location of project to reach the populations at most risk for overdose and death. Contracts are performance-based, and are based on the number of new inductions, retention and OTN size.

(For FFY 2021, there will be 14 OTNs - $302,975 moved to T14, Contingency Management Training).

1. **Contingency Management Training** (FFY 2021 only - $302,975 from T1)
   CM is an evidence-based behavioral intervention for substance use disorder. It provides incentives to individuals contingent upon objective evidence of the target behavior, such as a negative urine drug test, to increase the likelihood of these behaviors, which are essential components and outcomes of effective treatment. This contract will provide for training and fidelity monitoring of the OTNs and H&S.

2. **OTN TA/Training** – ($500,000 SOR) – T2 (opioid response plan strategy 2.2)
   DBHR is entering into a performance-based contract with the University of Washington, Alcohol and Drug Abuse Institute (ADAI) to provide technical assistance and training to support OTN development and monitoring.

3. **OTN Tobacco Cessation - T4 – (**$459,000- Tobacco Cessation @$329,000 and One FTE @$130,00)
   DBHR contracts with the Department of Health (DOH) to provide services for SOR projects and SOR funded clients, including WA Tobacco Quitline services, such as phone counseling and nicotine replacement therapy, Tobacco Treatment Specialist (TTS) training for SOR contractor's staff and training for providers on cross-addiction and Quitline referrals processes.

4. **Grants to Tribal Communities –T5 -** $372,500 (opioid response plan strategy 1.1)
   Tribal prevention and treatment grants to 21 tribes @ 12,500 each total $262,500 and 2 Urban Indian Health Programs ($100,000), are designed to meet the unmet needs of previous state opioid tribal requests. Development of a Tribal Opioid Epidemic Response Workgroup ($10,000). (For FFY 2021, $50,000 moved to Opioid Summit P10)

5. **OUD Treatment Decision Re-entry Services & COORP –** ($1,981,352 SOR II – T6 (opioid response plan strategy 2.4)
   WA-Opioid STR together with the Department of Corrections (DOC) has developed and is operating two programs. The reentry work-release and violator programs are in five communities across Washington State and provide re-entry services for discharging work-release and parole violators who have been identified as having OUD. The second program; Care for Offenders with OUD Releasing from Prison (COORP), identifies incarcerated individuals with OUD, expected to be released, and connects individuals to medication for opioid use disorder (MOUD) services in the county of their release, and expedites their enrollment in a Medicaid health plan.
6. **Tribal Treatment** – T8 SOR II $120,000

   Description: Create and distribute media campaigns for tribes to build awareness related to MAT/OUD treatment options for Native Americans ($131,511). The goal of the project is to work collaboratively with recognized tribal governments to engage in MAT services.

7. **WSU Contracted Services** – ($521,557 SOR**)** – T7 and P5 combined
   Contracted WSU Position for 1.0 FTE Treatment Manager, responsible for contract monitoring and training related to subrecipient grantees and state partners funded with the SOR. This position will be an

integral part of the current substance use disorder and mental health treatment team as they will ensure all SOR treatment works in tandem with current treatment efforts and prevents service duplication. 1.0 FTE for Communication Lead to manage media for SOR. 1.0 FTE Prevention Services Manager position responsible ensuring all SOR prevention works in tandem with current efforts and prevents service duplication.

8. **Opioid Treatment Network Hub & Spokes –** ($4,437,324 SOR) **–** T3
Description: DBHR utilizing STR funding expanded access statewide access to MAT by developing and implementing a six Hub & Spoke model. SOR supplemental funding will maintain and augment the model. Hubs are regional centers serving a defined geographical area that support spokes. Hubs will be responsible for ensuring that at least two of the three Federal Drug Administration (FDA) approved MATs are available. Spokes (five per hub) are facilities that will provide behavioral health treatment and/or primary healthcare services, wrap around services, and referrals to patients referred to them by the hub. The goal of the project is to increase access to MAT services statewide.

Recovery Support Services - $5,062,184

1. **OUD and MAT Training to Community Recovery Support Services** ($15,000 SOR II + SOR I NCE $14,696) – R1 (opioid response plan strategy 2.2.5)
TA/training will be provided to staff at: Catholic Community Services in Burlington, Everett Recovery Café, Peer Washington, Comprehensive Healthcare in Walla Walla, Okanogan Behavioral Healthcare, Spokane Recovery Café, and Vancouver Recovery Café. Recovery Support Staff will be provided training costs and expenses to attend the Region X Opioid Symposium.
2. **Client-directed Recovery Support and Peer Services** ($3,531,212 SOR II) – R2 & R3 (opioid response plan strategy 2.2.5)
Contracted direct recovery support and peer services to Catholic Community Services in Burlington, Everett Recovery Café, Peer Washington, Comprehensive Healthcare in Walla Walla, Okanogan Behavioral Healthcare, Spokane Recovery Café, and Vancouver Recovery Café. Recovery support services will be person directed and will include peer services/recovery coaching, and recovery planning. Additional

services (employment support, housing support, mentoring, dental care not covered by Medicaid, medical care not covered by Medicaid, basic needs, education support, etc.) will be based on each individual's need and request for support.
3. **Pathfinder Peer Project** ($1,505,972 SOR) – R4
Description: Provide outreach and engagement services to individuals who are homeless/risk of homelessness and suspected of Opiate Use Disorders (OUD) and/or Stimulant Use Disorder (SUD) in two environments, emergency rooms and homeless encampments. Assist individuals with suspected OUD/SUD

to access Medication for Opiate Use Disorder (MOUD) Services, Intensive Out/In patient SUD treatment, access Medicaid and other governmental funding such as SNAP.

Washington State Project to Prevent Prescription Drug/Opioid Overdose (WA-PDO)

A collaborative five-year project between DBHR and the University of Washington Alcohol and Drug Abuse Institute (ADAI) with the purpose of preventing opioid overdose and deaths from opioid overdose, and building local infrastructure to plan, implement, evaluate, and fund overdose prevention efforts in the long-term. $1,000,000 per year for 5 years.

Naloxone Distribution: University of Washington Alcohol and Drug Institute: Washington State Project to Prevent Prescription Drug/Opioid Overdose (WA-PDO) Grant – 2016 to 2021

Naloxone distribution to 5 High Need Areas (HNA) across Washington State. Each HNA includes multiple counties. Kit distribution started in January 2017.

January 2017 to August 2021 Individuals Trained: 16,214
Naloxone Kits Distributed: 55,155 (includes refills)
Overdose Reversals: 9,190

This grant completed on August 30, 2021.

Washington State Project to Prevent Prescription Drug/Opioid Overdose (WA-PDO)

A collaborative five-year project between DBHR and the Washington State Department of Health with the purpose of preventing opioid overdose and deaths from opioid overdose, and building local infrastructure to plan, implement, evaluate, and fund overdose prevention efforts in the long-term. $850,000 per year for 5 years.

Naloxone Distribution: Washington State Department of Health: Washington State Project to Prevent

Prescription Drug/Opioid Overdose (WA-PDO) Grant – 2021 to 2026

Naloxone distribution to 5 High Need Areas (HNA) across Washington State. Each HNA includes multiple counties, for a total of 18 partner agencies.

Year 1: (September 2021 to August 2022)

Individuals Trained: 2,721
Naloxone Kits Distributed: 12,494 (includes refills)
Overdose Reversals: 1,957

Year 2: (September 2022 to March 2023 – most current data)
Individuals Trained: 2,633
Naloxone Kits Distributed: 17,861 (includes refills)
Overdose Reversals: 2,366

This grant continues through August 30, 2026.

Washington State Department of Health (DOH)

December 1, 2018 through September 30, 2019 ($864,000)
October 1, 2019 through September 30, 2020 ($864,000)
October 1, 2020 through September 30, 2021 ($864,000)
October 1, 2021 through September 30, 2022 ($864,000)
October 1, 2022 through September 30, 2023 ($864,000)
October 1, 2023 through September 30, 2024 ($2,500,000)
October 2, 2024 through September 30, 2025 ($2,500,000)

Funding from the SABG is allocated for naloxone distribution. This was part of the sustainability plan to continue naloxone distribution statewide after the original WA-PDO grant ended August 31, 2021. There was an initial set of requests for 10,344 kits (both nasal and intramuscular) from 32 requesters in March and April 2019. DOH began distribution in April 2019.

April 2019 to September 2019: 7,527 kits distributed, 3,468 individuals trained, and 459 reported overdose reversals.

October 2019 to September 2020: 12,540 kits distributed, 7,204 individuals trained, and 2,185 reported overdose reversals.

October 2020 to September 2021: 21,204 kits distributed, 8,730 individuals trained, and 4,383 reported overdose reversals.

October 2021 to September 2022: 31,020 kits distributed, 14,129 individuals trained, and 5,599 reported overdose reversals.

October 2019 to most current data through March 2023: 25,350 kits distributed, 12,318 individuals trained, and 4,040 reported overdose reversals.

Co-Occurring Disorders

DBHR convened a workgroup to begin creating a plan, process, and structure that supports treatment and recovery for individuals who experience a substance use and mental health disorder. Individuals who experience a co-occurring disorder (COD) have one or more substance use related disorders as well as one or more mental health related disorders.

The workgroup agreed that the plan for a co-occurring WAC should be looked at but there was not enough time to make the needed changes by July 1, 2018. Creating a single set of rules would accomplish the goals of the workgroup as required by House Bill 1819 and stay within DBHR scope of authority. The certification responsibilities moved to the Department of Health July 2018.

The group considered definitions associated with substance use related disorders, mental health disorders, co-occurring disorders, and programs these definitions are included in TIP 42. Key issues considered included integrated screening, assessment, and treatment planning although current WAC related to previous legislation requires the use of the GAIN SS screening for both MH and SUD issues and a co-occurring assessment. Individuals with COD are best served through an integrated service plan that addresses both substance use and mental health disorders in one or program or at the same time with an integrated plan.

The integrated WAC was completed and implemented statewide, as mentioned the group agreed that work on a co-occurring WAC would not be able to be accomplished in the time allowed.

Effective July 2, 2020, Washington state implemented a Behavioral Health Co-Occurring Disorder Specialist enhancement under the Washington Administrative Code. WAC 246-804 defines a Co-Occurring Disorder Specialist as an individual who possesses “an enhancement granted by the department under chapter 18.205 RCW and this chapter that certifies the individual to provide substance use disorder counseling subject to the practice limitations under RCW 18.205.105.” In addition, the recent code created an application process

through which an individual can apply for the enhancement credential. There are specific training standards which have to be met for someone to qualify for the enhancement.

Beginning in 2020, we began working on a substantial overhaul to our Medicaid state plan to modernize our rehabilitative services section, which is the main section leveraged by our licensed behavioral health agencies. Historically, this section was written in two siloes by different state agencies; 1) mental health services; and 2) substance use disorder services. Under integrated care, the state plan is now fully overseen by the HCA. Over the past year, we have received technical assistance from CMS and have collaborated with our tribal partners and key stakeholders to develop a draft state plan amendment to be submitted to CMS in July 2023. This state plan amendment is written in a more cohesive manner, to intentionally avoid siloing mental health and substance use disorder treatment. The new format paves the way for more strategic planning around true co-occurring services. Additionally, specific services, such as stabilization services and community integration have been broadened to allow for additional provider types such as substance use disorder professionals. Allowable provider types for substance use have also been broadened to both align and recognize the full scope of practice for licensed counselors and social workers, further paving the way for more integrated care and flexible use of our limited workforce. Once approved by CMS, the state plan amendment will go into effect January 2024. As we move forward into 2024-2025, the next phase of our work will involve close collaboration with our tribal partners and stakeholders to consider additional changes to the state plan and existing Washington Administrative Codes to further bolster, define, and expand co-occurring services. Listening and collaboration with those who have received or are receiving services, as well as peers and others with lived experience will also be key to this work.

In summary, there are several workstreams and options to be considered as a multi-pronged approach to co-occurring services. These options include but are not limited to future state plan amendments, rule revisions, program development to better define co-occurring care, as well as collaboration with our payors and actuaries around different contracting and payment bundles that best support co-occurring services.

Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system.

Narrative Question:

This step should identify the unmet service needs and critical gaps in the state's current systems, as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's behavioral health system, including for other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps. The state's priorities and goals must be supported by data-driven processes. This could include data that is available through a number of different sources such as SAMHSA's National Survey on Drug Use and Health (NSDUH), Treatment Episode Data Set (TEDS), National Survey of Substance Use Disorder Treatment Services (N-SSATS), the Behavioral Health Barometer, **Behavioral Risk Factor Surveillance System (BRFSS)**, **Youth Risk Behavior Surveillance System (YRBSS)**, the **Uniform Reporting System** (URS), and state data. Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States with current Partnership for Success discretionary grants are required to have an active SEOW.

This narrative must include a discussion of the unmet service needs and critical gaps in the current system regarding the MHBG and SUPTRS BG priority populations, as well as a discussion of the unmet service needs and critical gaps in the current system for underserved communities, as defined under **EO 13985**. States are encouraged to refer to the **IOM reports**, *Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement* and ***The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding***[1] in developing this narrative.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Washington State Health Care Authority

Washington

UNIFORM APPLICATION
FY 2024/2025 – STATE BEHAVIORAL HEALTH ASSESSMENT AND PLAN

SUBSTANCE USE PREVENTION TREATMENT AND RECOVERY SERVICES
and
COMMUNITY MENTAL HEALTH SERVICES
BLOCK GRANT

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

and

Center for Mental Health Services
Division of State and Community Systems Development

Division of Behavioral Health and Recovery
FFY24-FFY25 Block Grant Application
September 1, 2023

IDENTIFY THE UNMET SERVICE NEEDS AND CRITICAL GAPS WITHIN THE CURRENT SYSTEM

This step should identify the unmet service needs and critical gaps in the state's current systems, as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's behavioral health system, including for other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps. The state's priorities and goals must be supported by data-driven processes. This could include data that is available through a number of different sources such as SAMHSA's National Survey on Drug Use and Health (NSDUH), Treatment Episode Data Set (TEDS), National Survey of Substance Use Disorder Treatment Services (N-SSATS), the Behavioral Health Barometer, ***Behavioral Risk Factor Surveillance System (BRFSS)****,* ***Youth Risk Behavior Surveillance System (YRBSS)****, the* ***Uniform Reporting System*** *(URS), and state data. Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States with current Partnership for Success discretionary grants are required to have an active SEOW.*

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WASHINGTON STATE NEEDS ASSESSMENT

Washington State integrated substance use disorder and mental health purchasing in April 2016 and completed the process of moving to integrated care with primary health in January of 2020. These changes have driven substance use disorder treatment services from a fee-for service program to a managed care model which required changes in how data is being collected. Due to the change, the MHD-CIS and TARGET data systems needed to be replaced by an integrated Behavioral Health Data System (BHDS) and Provider One (claims-based data system).

The one caveat to the integration is with the Tribal government, who through a 2016 consultation requested to maintain the TARGET system for data collection, until a data solution is found in collaboration with Tribes. Therefore, tribes serving Native and non-Native individuals within their community will continue to report these encounters in TARGET

The BHDS system has modernized the flow of data, provided increased security, improved accountability, and increased transparency of information, which will assist in refined management decisions and policy development. This system has also strengthened the monitoring and quality of the service delivery system, enhanced outcome analysis for the entire organization, and will further align the organization to a managed care model while maintaining Division of Behavioral Health and Recovery's (DBHR) ability to track priority outcomes, such as employment and housing for adults with serious mental illness (SMI). Through legislative direction in 2013, Research and Data Analysis (RDA) created a dashboard to measure the outcomes of the system. Using their Integrated Client Data system RDA is able to match administrative data records from multiple administrative data systems including BHDS to provide and measure outcomes. This same legislation (2SSB5732) also directed the Washington State Institute for Public Policy (WSIPP) in partnership with DBHR to create an inventory of evidence-based, research-based, and promising practices of interventions in adult mental health and substance use treatment services.

To make data-informed needs assessments with planning, policy development, service provision, and reporting DBHR continues to integrate stakeholder input, including input from the Behavioral Health Advisory Council, as well as the independent peer review summaries. Additionally, the State Epidemiological Outcomes Workgroup (SEOW) plays an important role in primary prevention planning. The SEOW fosters collaboration across Washington State agencies and partners in surveillance and research to inform program planning to reduce substance abuse and promote mental health in Washington State. The SEOW is sponsored by DBHR and supports agencies and partners in Washington State by collecting, interpreting, reporting, and advising on epidemiological and client service information that facilitates data-guided decision making among agencies and partners. Members of SEOW meet quarterly and membership includes data experts, epidemiologists, and evaluators from multiple state agencies, universities, as well as the Urban Indian Health Institute. DBHR is committed to ensure that tribal behavioral health needs define statewide needs by including representatives from the Northwest Portland Area Indian Health Board Epidemiological Center and the Urban Indian Health Institute as members for the SEOW. The SEOW collects and provides guidance on the collection of data related to substance use and mental health, including consumption and prevalence, consequences of use, and intervening variables. Data is sourced from both national and state surveys and administrative databases and is collected statewide covering all age and demographic groups. To allow for more in-depth geographic analysis, data are maintained at the lowest geographical level possible which allows Washington to support community-based initiatives. The SEOW serves as the primary data workgroup for the Washington State Prevention Enhancement (SPE) Policy Consortium's State Substance Abuse Prevention and Mental Health Promotion Five-Year Strategic Plan. Using a data-based approach, the Washington State Prevention Enhancement (SPE) Policy Consortium is updating the state's Substance Use Disorder Prevention and Mental Health Promotion Five-Year Strategic Plan, to completed in July 2023. The SPE Policy Consortium is comprised of representatives from over 20 state and tribal agencies and organizations. The goal of the Consortium is that

through partnerships Washington will strengthen and support an integrated system of community-driven substance use disorder prevention programming, mental health promotion programming, and programming for related issues. The current State of Washington Substance Use Disorder and Mental Health Promotion Five-Year Strategic Plan was developed in 2012. It was updated in 2015, 2017, and 2019 and both past plans and the current plan are posted on the Athena Forum The SPE Policy Consortium has just completed an in-depth five-year strategic planning process, undergoing a needs and resources assessment, diving deep into the community and state level workforce and training needs, and identifying policy and programmatic areas that need a greater focus in the next five years, such as dedicating efforts to support populations of focus with substance use disorder prevention and mental health promotion programs, and implementing environmental strategies to reduce access and availability of substances

Strategy to Identify Unmet Needs and Gaps

DBHR's Recovery Support Services utilizes the Peer Support Advisory Group to inform HCA of needs and gaps around training and certifying peers. Some of these topics include increasing the diversity of HCA approved trainers and training organizations and updating and creating curriculum that meets the needs of the peer workforce. Recovery Support Service program managers do site visits and solicit voice of the people receiving the services to identify strengths and barriers to services. In SFY 2022 the Recovery Support Services in partnership with the Office of Recovery Partnerships held listening sessions across the state with three marginalized populations to include, Black, Hispanic, and AI/AN. These listening sessions collected information on strengths and barriers in accessing and receiving services.
HCA supports the American Indian/Alaska Native Opioid Response workgroup, in partnership with the American Indian Health Commission. This workgroup discusses successes, strengths, and gaps within the system to address the opioid crisis and significantly higher rates of opioid and fentanyl use disorders, overdoses, and deaths. The Native Transformation project conducted by the Northwest Indian College and 3 Tribes in the north sound region, identify protective factors for opioid prevention and recovery. In 2023, Tribal elected leaders and the state governor sat together to discuss solutions needed to address this significant crisis and follow up work will be needed to implement those strategies.
DBHR utilizes a number of local reports that indicate need and usage of the inpatient, Involuntary Treatment Act (ITA), and crisis systems. This information informs planning to address gaps in inpatient, crisis, and diversion capacity. This information also informs the work that DBHR is doing to shift long term involuntary treatment from the state psychiatric hospitals to contracted community settings.

DBHR's planning of prevention and treatment services draws on data from various sources. The biennial statewide **Healthy Youth Survey (HYS)** provides reliable estimates of substance use prevalence and mental health indicators as well as risk factors that predict poor behavioral health outcomes among

adolescents in grades 6, 8, 10, and 12. The survey, supported by four state agencies and in over 80 percent of the state's public schools, is used by DBHR to estimate prevalence rates at state, county, Behavioral Health Organizations, Accountable Communities of Health, school districts, and school building levels. After a postponement of 2020 HYS due to the COVID-19 pandemic, the most recent HYS was conducted as an electronic survey in the fall of 2021 and provided data for DBHR's needs assessment, including broadening surveillance capacity for LGBTQ+ communities, adolescent anxiety, and substance use issues related to vapor products. The next HYS will be administered in fall 2023 and include expanded reporting capacity including an online data dashboard.

The HCA has partnered with state agencies tribal liaisons to develop a plan to improve tribal engagement and data accessibility for tribal health and school partners. We have also invested in support to hire a fellow that will help this sub workgroup complete tasks outlined in this plan.

For young adults, adults, and older adults, the main data sources for prevalence estimates and epidemiological analyses are **the National Survey on Drug Use and Health (NSDUH),** the **Behavioral Risk Factor Surveillance System (BRFSS)**, and the **Washington Youth Adult Health Survey (YAHS)**. NSDUH is used to estimate and monitor substance use prevalence rates for various types of substances and BRFSS provides information to identify needs and gaps among various demographic and socioeconomic subpopulations. For example, the Washington BRFSS includes questions that allow us to identify pregnant/parenting women and the LGBTQ subpopulations. However, the small sample size limits the ability to create estimates for these subpopulations without combining multiple years of data, and the minimal number of questions about cannabis and alcohol on these surveys limits the ability to assess how recent policy changes are shaping substance use patterns. DBHR has partnered with researchers at the University of Washington to conduct the YAHS as an expansion to the State's Healthy Youth Survey (HYS). The YAHS measures cannabis and other substance use, perceptions of harm, risk factors, and consequences among young adults (18 to 25 years old) living in Washington State. The SEOW member agencies and partners advise survey development and implementation. The SEOW will continue to assess data for priority populations and advise on potential data sources to address these gaps.

The use of evidence-based practices (EBP) in the field of behavioral health is very well established.
The Washington State Legislature has acknowledged the importance of EBPs in children's mental health and adult behavioral health services. DBHR has established a partnership with the University of Washington's Evidence-based Practice Institute (EBPI) to assess the need for evidence-based practices in the children's behavioral health system. The collaboration aims to formulate EBP reporting guidelines and to monitor the use of EBPs by providers and identify gaps in EMP implementation using data from BHDS. As mentioned earlier the Washington State Institute for Public Policy (WSIPP) identified a three-step process for identifying EBP,

RBP and PP for adult behavioral health services through a rigorous meta-analysis of the research, costs and return on investment of the intervention and conducting a risk analysis of the results. Through this work, HCA has also learned and understands the need to support promising and tribal best practices along with EBPs.

Primary prevention services are chosen by sub-recipients from a list of approved evidence-based programs and strategies created by Washington State's Evidence-Based Program Workgroup (EBP Workgroup). The list is posted on the Athena Forum website (https://www.TheAthenaForum.org/EBP). The EBP Workgroup is comprised of researchers and experts from University of Washington's Social Development Research Group and Washington State University's Improving Prevention through Action Research Lab, with input from the Washington State Institute for Public Policy, the prevention research sub-committee, and Pacific Institute for Research and Evaluation. The list was developed with programs and strategies that came from three primary resources: the National Registry for Evidence-based Programs and Practices (NREPP), a separate list of programs identified as evidence-based by the State of Oregon; and the Pacific Institute for Research and Evaluation's (PIRE) “Scientific Evidence for Developing a Logic Model on Underage Drinking: A Reference Guide for Community Environmental Prevention” report.

For specific priority subpopulations, including persons using intravenous drugs and pregnant, person with a substance use disorder and pregnant, persons who use intravenous drugs, and women with dependent children, data will be drawn from other state surveys and administrative databases as well as service data to identify the un-met need. For example, we will use data from the **Pregnancy Risk Assessment Monitoring System (PRAMS)** to estimate the prevalence of substance use among pregnant women and treatment data to identify the rate of treatment for persons who use drugs while pregnant. When prevalence data is unavailable for certain priority subpopulations, such as women with dependent children, treatment data will be used to monitor rates of admission to SUD treatment. The SEOW will identify data gaps for priority subpopulations and advise on potential data sources. At the sub-state level, we will use a synthetic process to estimate substance abuse treatment needs. This process combines data from US Census sources for geographic and demographic subgroups to “expand” the NSDUH state-level estimates of AOD treatment need into the desired subgroups (defined by poverty level, age, race/ethnicity, gender). Detailed community level needs and resources assessments will be used to develop strategic plans to support the individual, community, and local system level. In addition to HYS, the **Community Outcomes and Risk Evaluation (CORE) System** will be used in community level needs assessments to include updating an annual risk ranking to aid DBHR in identifying high-need communities to target prevention services. In this process, HYS and archival data on key substance use and consequence indicator from the CORE Geographic Information System (GIS) are used to create a county-level risk profile and a community-level composite risk score for each community where school district service areas are the proxy. Communities are ranked statewide and assigned a percentile ranking according to their risk level based on the composite risk score. The CORE GIS, developed as a set of social indicators highly

correlated with adolescent substance use, are kept at the lowest possible level (at least county level, and address level in some instances). Most indicators originate from the Department of Health (including the Prescription Monitoring Program), DSHS, the Uniform Crime Report, and the Office of Superintendent of Public Instruction. The most recent update was in spring of 2021. Due to HYS and CORE data available at the community and school level, communities and neighborhoods can be identified that otherwise might be overlooked if data were only available at larger geographic units.

In 2021, the WA State legislature passed SB 5476 in response to the state Supreme Court ruling that the state's current drug possession laws were unconstitutional and directed HCA to assemble the Substance Use Recovery Services Advisory Committee (SURSAC) to collaborate with HCA to write a new Substance Use Recovery Services Plan for the state. In 2022, the SURSAC met monthly with HCA to discuss needs within the SUD continuum of care in Washington State and made several recommendations to address them, which were submitted to the legislature at the beginning of 2023, for consideration during the 2023 legislative session. Most of the recommendations were adopted and funded via the state budget bill (SB 5187) and/or the new "Blake" bill, SB 5536. The adopted recommendations span housing needs (e.g., investing in and incentivizing recovery residences), bolstering efforts to divert people who use substances from entanglement in the criminal legal system (e.g., investments to support and expand LEAD, AJA, and RNP), and building out harm reduction and treatment infrastructure (e.g., piloting Health Engagement Hubs for people who use drugs, expanding opioid treatment programs and medication units, especially in rural areas), and ensuring that the impact of these investments can be assessed through new data infrastructure and reporting requirements.

Strategy to Align Behavioral Health Funding with Unmet Needs and Gaps

The funding allocation methodology for non-Medicaid services was reviewed as part of the integration of mental health and substance use disorder treatment for the Behavioral Health Organizations. Treatment needs by county, as well other factors such as county population, utilization patterns, penetration, and retention rates were also used for developing the methodology. After much review with stakeholders, the final methodology that was incorporated into the model is 70% prevalence, 20% penetration and 10% retention. Integrating these factors allows us to maintain focus on priority populations and the full continuum of care.

Mental health resource allocation will continue to be based on prevalence and treatment needs. For example, DBHR recently updated the state hospital bed allocation formula with current prevalence rates of serious mental illnesses and prior utilization rates.

Prevention funding, under the state's Community Prevention Wellness Initiative (CPWI) and through grants

awarded to Washington State community-based organizations (CBOs), are targeted to communities with the highest needs. In addition to **HYS**, the **Community Outcomes and Risk Evaluation (CORE) System** is used in to aid DBHR in identifying high-need communities to target prevention services. CPWI is unique in its approach to community selection because CPWI uses a data-informed community selection process. When funding is available, high-need communities according to their risk ranking, are eligible to apply.

Prioritize State Planning Activities

Priorities

Priority 1: Address High Disproportionate Rates of SUD and MH Disorders and Overdoses Amongst AI/AN/Individuals in WA State.
American Indians/Alaska Natives disproportion SUD and overdose rates continue to be a priority for HCA to address in partnership with tribal governments and urban Indian health organizations. This goal is focused on addressing these rates by offering a direct allocation to Tribes through our government-to-government Indian Nation Agreements.

Priority 14: Increase the number of adults receiving opioid use disorder treatment, support during recovery from OUD, and tools necessary to reduce deaths resulting from opioid overdose and poisoning.
HCA is committed to increasing the accessibility of treatment for individuals experiencing opioid use disorder, support individuals in recovery from opioid use disorder and reduce the harms associated with opioid use and misuse.

Priority 2: Reduce Underage and Young Adult Substance Use/Misuse.
The State Prevention Policy Consortium concluded that underage drinking remains the top priority for substance abuse prevention and mental health promotion for youth and adults. Marijuana ranked second due to high prevalence among youth. Depression, anxiety, and suicide prevention were also identified as behavioral health areas for which increased attention to capacity building is needed in support of mental health promotion. Tribal programs suggest that heroin is the drug of choice among youth on some reservations based on the analysis of these issues among sub-populations and in their own local assessments. Substance abuse prevention and mental health promotion should both focus on youth and young adults.

Priority 3: Increase the number of youths receiving outpatient substance use disorder treatment.
Priority 9: Increase the number of adults receiving outpatient substance use disorder treatment.

Issues around access, service timeliness, and engagement continue to be a focus of substance use disorder treatment services as the state supports integration of behavioral health services. The updated funding formula based on prevalence, penetration, and retention integrates the focus on the mandated priority populations (IVDU, PPW) and full continuum of care, while retaining the commitment to youth treatment, evidence-based practices, and statewide availability of services.

Priority 4: Increase the number of SUD Certified Peers.
HCA developed a peer support program to train and increase the number of SUD peers working in the field to incorporate SUD peer services into the behavioral health system.

Priority 5: Maintain outpatient mental health services for youth with SED.
Priority 7: Maintain the number of adults with SMI receiving mental health outpatient treatment services.
Mental health treatment services continue to focus on the block grant priority population: youth, adults, and older adults with serious emotional disorder (SED) or serious mental illness (SMI).

Priority 13: Increasing access to Behavioral Health Crisis Services through expansion of voluntary mobile crisis services.
HCA is focused on expansion of access to crisis services and reduction of unnecessary use of first responders and emergency departments to improve outcomes for those in crisis by providing ongoing stabilization services.

Priority 6: Increase capacity for early identification and intervention for individuals experiencing First Episode Psychosis.
HCA is committed to increasing the number of mental health community-based agencies who serve youth diagnosed with First Episode Psychosis.

Priority 8: Increase the number of individuals receiving recovery support services, including increasing supported employment services and supported housing services for individuals with SMI, SED and SUD.
HCA is committed to decreasing rates of homelessness and increasing rates of employment for adults with behavioral health issues while increasing awareness and using evidence-based practices to address these needs through our supported housing and supported employment programs. HCA would like to develop developmentally appropriate outreach and integration of supported employment and supported housing services for older youth and young adult populations.

Priority 10: Pregnant and Parenting Individuals with Dependent Children.
Pregnant and parenting individuals continue to be a priority population for substance use disorder services to improve their health and assist in maintaining recovery.

Priority 11: Tuberculosis Screening
Provide Tuberculosis screening at all SUD outpatient and residential provider agencies within their provider networks.

Priority 12: Workforce Innovation and Challenges
Workforce shortages within Washington state continue to present challenges in meeting the service needs for individuals with mental health disorders, substance use disorders and co-occurring disorders. Prioritizing workforce education and training and supporting awareness of and promotion of behavioral health careers is a high priority through the StartYourPath.org campaign.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Address high disproportionate rates of SUD and MH disorders and overdoses amongst AI/AN individuals in WA state.

Priority Type: SUP, SUT, SUR

Population(s): BHCS, PWWDC, PP, PWID, TB, Other

Goal of the priority area:

The goal of this priority is to address the disproportionately high rates of SUD and MH disorders for AI/AN individuals across the state. This goal is focused on addressing these rates by offering a direct allocation to Tribes through our government-to-government Indian Nation Agreements. The INA is an agreement between the HCA and Tribal governments to fund services as deemed appropriate by the Tribes to address substance use disorders using SABG dollars.
The Health Care Authority follows the RCW 43.376 and a communication and consultation policy which outlines the state regulations for G2G relationships with Tribes. The Office of Tribal Affairs assists DBHR in implementation of various consultation and confirm meetings with the 29 Tribes and urban Indian health programs. By extension of the Accord and our HCA Tribal Consultation Policy, HCA offers all 29 Tribes the opportunity to access substance abuse block grant funding to help bolster prevention, treatment, overdose intervention, and recovery support services within their tribal communities.

Strategies to attain the goal:

• Each tribe is requested to complete an annual Tribal Plan and budget that indicates how the funding will be expended for the delivery of SUD prevention, intervention, treatment, and recovery support activities which is negotiated with HCA program managers with the support of the Office of Tribal Affairs.
• Each tribe submits quarterly fiscal and programmatic reports to HCA.
• Each tribe inputs data into each appropriate data system (i.e., TARGET Data System, and Substance Use Disorder (SUD) Prevention and MH Promotion Online Data System) on a quarterly basis with the support of HCA program managers.
• Each tribe submits an Annual Narrative Report to reflect on the prevention and treatment services provided with the funding, successes within the program, challenges within the program, etc.
• HCA coordinates a biennial desk monitoring review with each Tribe as negotiated through a formal consultation process.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Maintain substance use disorder prevention, intervention, treatment, and recovery support services to American Indian/Alaska Natives.

Baseline Measurement: SUD Treatment Outpatient Services - Individuals Served: 3,355 SUD Prevention – Average of 51,714 total unduplicated and duplicate participants served by direct tribal prevention services provided during SFY22 (July 1, 2021 – June 30, 2022) Opioid Treatment Programs (OTPs) within Tribes: Seven OTPs for SFY22

First-year target/outcome measurement: SUD Treatment Outpatient Services - Individuals Served: 3,355 SUD Prevention – Increase or maintain 51,714 total unduplicated and duplicate participants in direct services prevention programs SUD MOUD – Increase tribal MOUD and OTPs to a total of eight OTPs available in Tribal communities.

Second-year target/outcome measurement: SUD Treatment Outpatient Services - Individuals Served: 3,355 SUD Prevention – Increase or maintain 51,714 total unduplicated and duplicate participants in direct services prevention programs SUD MOUD – Increase tribal MOUD and OTPs to a total of ten OTPs available in Tribal communities.

Data Source:

TARGET, or its successor, for treatment counts.
Minerva – SUD Prevention and MH Promotion Online Reporting System (Washington’s Prevention Management Information Service): used to report SABG prevention performance indicators.

Description of Data:

As reported into TARGET and Minerva by Tribes, total number of AI/AN clients served between July 1, 2021 and June 30, 2022.

Data issues/caveats that affect outcome measures:

• Indian Health Care Providers must enter data into multiple systems in their work to improve health information technology in their programs which is burdensome. Tribes are working to move to EHRs, are using an Indian Health Services System, plus the state data systems which are often duplicative and can be expensive to dedicate additional staff to enter data into multiple systems.
• TARGET is the system that is used by Tribes that is then transmitted into our Behavioral Health Data Store and HCA needs to sunset this system and move to a new solution for the Tribes. HCA is working on a pilot project to identify a solution to gather the SUD encounter data in the future without the TARGET system.
• SUD Prevention numbers may include duplication of client counts due to Tribes reporting number of people in attendance at events for each day.
• Additionally, the prevention reporting system transitioned to a new vendor in the fall of 2021 and Tribes had to learn a new system. HCA provides technical assistance to Tribes on the new system to minimize impact of system changes.

Priority #: 2

Priority Area: Reduce Underage and Young Adult Substance Use/Misuse

Priority Type: SUP

Population(s): PWWDC, PP, PWID

Goal of the priority area:

Decrease the use and misuse of alcohol, cannabis, tobacco, opioids or other prescription drugs, and the use of any other drugs in the last 30 days.

Strategies to attain the goal:

• Implement performance-based contracting with each prevention contractor.
• Adapt programs to address the unique needs of each tribe.
• Strategies to serve AI/AN communities with increased risk for SUD concerns through various prevention projects using leveraged resources and ensure culturally appropriate services.
• Deliver Evidenced-based Prevention Programs and Strategies according to approved strategic plans.
• Deliver direct prevention services (All CSAP Strategies).
• Deliver community-based prevention services (Community-based process, Information Dissemination and Environmental).
• Disseminate state level public education campaigns with toolkits for localized implementation.
• Provide statewide Workforce Development Training to build capacity for service delivery.
• Develop and implement best practices strategies to target underserved populations such as Tribal and urban Indian communities, Black, Indigenous, and People of Color and LGBTQ+.
• Increase direct service programs for young adults.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Reduce substance use/misuse

Baseline Measurement: Average of 12,217 unduplicated participants served by direct services provided between SFY 2020-2022 (July 1, 2020 – June 30, 2022)

First-year target/outcome measurement: Maintain a minimum of 12,217 unduplicated participants in direct services prevention programs.

Second-year target/outcome measurement: Maintain a minimum of 12,217 unduplicated participants in direct services prevention programs.

Data Source:

Minerva - SUD Prevention and MH Promotion Online Reporting System (Washington’s Prevention Management Information Service): used to report SABG performance indicators.
Washington State Healthy Youth Survey (HYS): used to report 30 days use biannually.
Washington State Young Adult Health Survey (YAHS): used to report young adult (Ages 18-25) substance use/misuse.

Description of Data:

SABG performance indicators are used to measure Center for Substance Abuse Prevention Strategies and Institute of Medicine Categories for services provided annually. From HYS, 10th grade Substance Use Among Washington Youth is used to measure

intermediate outcomes. From Washington State Young Adult Health Survey (YAHS), Substance Use Among Washington young adults is used to measure intermediate outcomes.

Data issues/caveats that affect outcome measures:

Data integrity can be negatively affected by staff turnover and contractor capacity to report accurately and in a timely manner. DBHR continues to provide on-going training and technical assistance to support grantees as they use the Management Information System. Additionally, the prevention reporting system transitioned vendors in Fall 2021 and all staff and providers have been learning the new system, this may increase data reporting challenges in some areas. The new system has some limitations that we are currently navigating and strategizing in order to ensure efficient, proper and accurate data entry. HCA is working to ensure all providers are supported and engaged in this process to minimize the impact.

Priority #: 3

Priority Area: Increase the number of youths receiving outpatient substance use disorder treatment

Priority Type: SUT

Population(s): PWWDC, PP, PWID

Goal of the priority area:

Increase the treatment initiation and engagement rates among the number of youths accessing substance use treatment outpatient services.

Strategies to attain the goal:

• Conduct behavioral health provider mapping efforts to identify current adolescent network. Identify access challenges and strategies to remove system barriers.
• Continue using performance-based contracts with BH-ASOs and MCOs to ensure focus and oversight of provider network.
• Continue efforts to actively engage youth in a co-design project to begin reimagining what a better continuum of care for youth and young people with SUT needs.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase youth outpatient SUD treatment services

Baseline Measurement: SFY22 (July 1, 2021 – June 30, 2022): 1,690 youth received SUD outpatient treatment services

First-year target/outcome measurement: Increase the number of youths receiving SUD outpatient treatment services in SFY24 to 1,900

Second-year target/outcome measurement: Maintain the number of youths receiving SUD outpatient treatment services in SFY25 to 1,900

Data Source:

The number of youths receiving SUD outpatient services is tracked using the Behavioral Health Data System (BHDS).

Description of Data:

The calendar year 2022 data is an unduplicated count of youth (persons under 18 years of age) served in publicly funded SUD outpatient treatment between July 1, 2021, and June 30, 2022.

Data issues/caveats that affect outcome measures:

DBHR has integrated behavioral health services with physical healthcare coverage, which has caused data reporting challenges. The entities submitting encounter data and how data is being submitted has changed.

Priority #: 4

Priority Area: Increase the number of SUD Certified Peers

Priority Type: SUT, SUR

Population(s): PWWDC, PP, PWID, TB

Goal of the priority area:

Increase the number of SUD peers working in the field, create a strategic plan to incorporate SUD peer services into the behavioral health system.

Strategies to attain the goal:

• HCA/DBHR will seek input from key stakeholders and certified peers to guide the development of a strategic plan incorporating peer services within the substance use treatment service delivery system
• Identify any curriculum adjustments needed to integrate SUD peer services
• Strategic planning to incorporate SUD peer services into the system of care, exploring funding strategies and rule changes
• Focus on diversity, equity and inclusion practices, including services for AI/AN Tribal communities, to improve diverse peer services in underserved communities.
• Increase recruitment of BIPOC Certified Peer Counselors (CPC's) and increase diversity of training organizations and CPC trainers.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: SUD peer support program

Baseline Measurement: From July 1, 2021 – June 30, 2022 total number of SUD trained peers was 488

First-year target/outcome measurement: Peer support program in SFY24 that would train 420 peers that could provide Medicaid reimbursable SUD peer services.

Second-year target/outcome measurement: Peer support program in SFY25 that would train 480 peers that could provide Medicaid reimbursable SUD peer services.

Data Source:

Monthly reports submitted to DBHR through the STR Peer Pathfinder project

Description of Data:

Excel reports indicating the number of individuals served by SUD Peers on the Pathfinder project

Data issues/caveats that affect outcome measures:

No issues are currently foreseen that will affect the outcome measures.

Priority #: 5

Priority Area: Maintain outpatient mental health services for youth with SED

Priority Type: MHS

Population(s): SED

Goal of the priority area:

The primary goal is to maintain community based behavioral health services to youth who are diagnosed with SED.

Strategies to attain the goal:

• Require MCOs and BH-ASOs to maintain behavioral health provider network adequacy.
• Maintain available MH community-based behavioral health services for youth diagnosed with SED.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Maintain outpatient Mental Health services to youth with Serious Emotional Disturbance (SED)

Baseline Measurement: SFY22: 76,941 youth with SED received services

First-year target/outcome measurement: Maintain the number of youths with SED receiving outpatient services to at least 76,941 in SFY24

Second-year target/outcome measurement: Maintain the number of youths with SED receiving outpatient services to at least 76,941 in

SFY25

Data Source:

The number of youths with SED receiving MH outpatient services is reported in the Behavioral Health Data System (BHDS).

Description of Data:

Fiscal Year 2022 is an unduplicated count of youth with Serious Emotional Disturbance (SED) who under the age of 18 served in publicly funded outpatient mental health programs from July 1, 2021 through June 30, 2022.

Data issues/caveats that affect outcome measures:

No issues are currently foreseen that will affect the outcome measure.

Priority #: 6

Priority Area: Increase capacity for early identification and intervention for individuals experiencing First Episode Psychosis (FEP) including FEP programs in diverse communities (I.e. Tribal Communities)

Priority Type: MHS

Population(s): SMI, SED, ESMI

Goal of the priority area:

The primary goal is to increase community based behavioral health services to transition age youth who are diagnosed with First Episode Psychosis (FEP).

Strategies to attain the goal:

• Provide funding to increase the number of agencies who serve youth with First Episode Psychosis (FEP)
• Increase available MH community based behavioral health services for youth diagnosed with First Episode Psychosis (FEP).
• New Journeys teams are currently working with one pilot site and will reach out to Tribal communities and health clinics to facilitate referrals for expanded access to FEP services.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase outpatient MH capacity for youth with First Episode Psychosis (FEP).

Baseline Measurement: SFY22: 12 First Episode Psychosis (FEP) Programs, serving a total of 308 youth

First-year target/outcome measurement: FY24 (July 1, 2023 – June 30, 2024) Increase the number of coordinated specialty care sites to 17 serving a total of 375 youth statewide.

Second-year target/outcome measurement: FY25 (July 1, 2024 – June 30, 2025) Maintain the 17 coordinated specialty care sites and begin implementation of adding up to three additional sites, with a total of 400 youth served statewide.

Data Source:

DBHR, via reporting from WSU. Extracted from the URS reports.

Description of Data:

Number of youth being served through the coordinated specialty care sites.

Data issues/caveats that affect outcome measures:

No issues are currently foreseen that will affect the outcome measure.

Priority #: 7

Priority Area: Maintain the number of adults with Serious Mental Illness (SMI) receiving mental health outpatient treatment services

Priority Type: MHS

Population(s): SMI, BHCS

Goal of the priority area:

Maintain the number of adults with Serious Mental Illness (SMI) accessing mental health outpatient services.

Strategies to attain the goal:

• Gather data and resources regarding how potential individuals are identified.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Maintain mental health outpatient services for adults with Serious Mental Illness (SMI)

Baseline Measurement: SFY22: 216,740 adults with Serious Mental Illness (SMI) received mental health outpatient services

First-year target/outcome measurement: Maintain a minimum of 195,046 adults with Serious Mental Illness (SMI) receiving mental health outpatient services in SFY24 (we anticipate a decrease in numbers, bringing us closer to our normal baseline pre-Covid)

Second-year target/outcome measurement: Maintain a minimum of 195,046 adults with Serious Mental Illness (SMI) receiving mental health outpatient services in SFY25 (we anticipate a decrease in numbers, bringing us closer to our normal baseline pre-Covid)

Data Source:

The number of adults with Serious Mental Illness (SMI) receiving Mental Health outpatient treatment services is tracked using the Behavioral Health Data System (BHDS).

Description of Data:

Fiscal Year 2022 clients served is an unduplicated count of adults with Serious Mental Illness (SMI) (persons 18 years of age and older) served in publicly funded mental health outpatient programs between July 1, 2021 and June 30, 2022.

Data issues/caveats that affect outcome measures:

With the combination of behavioral health services coverage, we are experiencing data reporting challenges due to the way data was collected previously.

Priority #: 8

Priority Area: Increase the number of individuals receiving recovery support services, including increasing supported employment and supported housing services for individuals with Serious Mental Illness (SMI), SED, and SUD

Priority Type: SUT, SUR, MHS

Population(s): SMI, SED, PWWDC, PP, PWID, TB

Goal of the priority area:

Measurements for this goal will include increasing the employment rate, decreasing the homelessness rate and providing stable housing in the community.

Strategies to attain the goal:

• Train 500 staff working in behavioral health, housing and health care, through webinars or in-person training events
• Support 1,000 individuals in obtaining and maintaining housing
• Support 1,000 individuals in obtaining and maintaining competitive employment
• Assist 25 behavioral health agencies in implementing evidence-based practices of permanent supportive housing and supported employment models

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase number of people receiving supported employment services

Baseline Measurement: FY2022 – 4,614 enrollments in supported employment

First-year target/outcome measurement: Increase number of people receiving supported employment services per month (over 12-month period) by 4% in FY24 (total 4,798 enrollments)

Second-year target/outcome measurement: : Increase number of people receiving supported employment services per month (over 12-month period) by 4% in FY25 (total 4,989 enrollments)

Data Source:

Department of Social and Human Services (DSHS), RDA

Description of Data:

Includes all people who have received supported employment services.

Data issues/caveats that affect outcome measures:

No issues are currently foreseen that will impact the outcome of this measure.

Indicator #: 2

Indicator: Increase number of people receiving supportive housing

Baseline Measurement: FY2022 – 7,353 enrollments in supportive housing

First-year target/outcome measurement: Increase average number of people receiving supportive housing services per month (over 12-month period) by 4% in FY24 (total 7,647 enrollments)

Second-year target/outcome measurement: Increase average number of people receiving supportive housing services per month (over 12-month period) by 4% in FY25 (total 7,952 enrollments)

Data Source:

Department of Social and Human Services (DSHS), RDA

Description of Data:

Includes all people who have received supported housing services.

Data issues/caveats that affect outcome measures:

No issues are currently foreseen the will impact this outcome measure.

Priority #: 9

Priority Area: Increase the number of adults receiving outpatient substance use disorder treatment, including those prescribed medications for opioid use disorder (MOUD)

Priority Type: SUT

Population(s): PWWDC, PP, PWID, TB

Goal of the priority area:

Increase the number of adults receiving outpatient SUD treatment including adults who receive medications for the treatment of opioid use disorder (e.g. Methadone, Buprenorphine, and/or Naltrexone).

Strategies to attain the goal:

• Explore new mechanisms and protocols for case management and continue using Performance Based Contracts to increase the number of adults receiving outpatient SUD and MOUD services.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase outpatient SUD and access to Medications for Opioid Use Disorder (MOUD) for adults in need of SUD treatment

Baseline Measurement: SFY22: 41,825; SFY 2020 Percent of Medicaid enrollees with OUD accessing Medications for

Opioid Use Disorder: All MOUD 39.2%, Buprenorphine/Bup-Naloxone 24.5%, Methadone 14.3%, Naltrexone 1.5%

First-year target/outcome measurement: Increase the number of adults with SUD receiving treatment in SFY24 to 47,875. Percent of Medicaid enrollees with OUD accessing Medications for Opioid Use Disorder: All MOUD 45%, Buprenorphine/Bup-Naloxone 27%, Methadone 16%, Naltrexone 2%

Second-year target/outcome measurement: Increase the number of adults with SUD receiving treatment in SFY25 to 48,888. Percent of Medicaid enrollees with OUD accessing Medications for Opioid Use Disorder: All MOUD 45%, Buprenorphine/Bup-Naloxone 27%, Methadone 16%, Naltrexone 2%

Data Source:

The number of adults receiving SUD outpatient services and MOUD is tracked using the Behavioral Health Data System (BHDS).

Description of Data:

Fiscal Year 2020 is an unduplicated count of adults (persons 18 years of age and older) served in publicly funded SUD outpatient treatment and/or receiving MOUD between July 1, 2019 and June 30, 2020.

Data issues/caveats that affect outcome measures:

With the combination of behavioral health services coverage, we are experiencing data reporting challenges due to the way data was collected previously.

Priority #: 10

Priority Area: Pregnant and Parenting Individuals

Priority Type: SUT

Population(s): PP

Goal of the priority area:

Increase the number of Pregnant and Parenting Individuals (PPI) clients receiving case management services

Strategies to attain the goal:

Increase access to case management services

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Expand capacity for women and their children to have access to case management services.

Baseline Measurement: SFY 2022, the total contracted number of Pregnant and Parenting Individuals (PPI) clients receiving PCAP case management services was 1,490 (an increase in capacity of 81 service spaces available to individuals).

First-year target/outcome measurement: SFY 2024 - Increase the number of Pregnant and Parenting Individuals (PPI) clients receiving PCAP case management services by 56 individuals served, totaling to a maximum contracted capacity of 1,546 service spaces available to individuals statewide.

Second-year target/outcome measurement: SFY 2025 - Maintain the number of Pregnant and Parenting Women (PPW) clients receiving PCAP case management services.

Data Source:

Contracts with PCAP providers.

Description of Data:

The contracts mandate that PCAP providers must submit the number of clients being served: 1) on their monthly invoices in order to be reimbursed, 2) to the University of Washing ADAI for monthly reporting.

Data issues/caveats that affect outcome measures:

If funding is reduced for any reason, the number of sites/clients served may decrease.

Priority #: 11

Priority Area: Tuberculosis Screening

Priority Type: SUT, MHS

Population(s): TB

Goal of the priority area:

Provide Tuberculosis screening at all SUD outpatient and residential provider agencies within their provider networks.

Strategies to attain the goal:

Review TB screening plans with the BH-ASOs for each of the state's ten regions during contract amendment cycles.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Provide TB screening and education at all SUD outpatient and residential provider agencies within their provider networks.

Baseline Measurement: As of July 1, 2022, Tuberculosis screening and education is a continued required element in the BH-ASO contract for SUD treatment services.

First-year target/outcome measurement: For SFY 2024, ensure TB screening plans continue to be in contract with each of the ten BH-ASOs.

Second-year target/outcome measurement: For SFY 2025, review TB screening plans prior to the BH-ASO amendment and update as needed to ensure screenings and education services are being provided during SUD treatment services.

Data Source:

Health Care Authority/BH-ASO Contracts

Description of Data:

The contracts between the Health Care Authority and the BH-ASOs will be maintained to include this language.

Data issues/caveats that affect outcome measures:

None

Priority #: 12

Priority Area: Workforce Innovation and Challenges

Priority Type: SUP, SUT, SUR, MHS, ESMI, BHCS

Population(s): SMI, SED, ESMI, BHCS, PWWDC, PP, PWID, TB

Goal of the priority area:

Workforce education and training supports

Strategies to attain the goal:

• Behavioral health recruitment and retention campaign
o Engaging audiences through passion, opportunity and connection to what they love about behavioral health career opportunities through an outreach and education campaign to the residents of Washington state. www.startyourpath.org
o Including toolkits and resources for supervisors and provider education.
• Continuing education and trainings for workforce:
o Designated Crisis Responder trainings
o Envisioning family leadership academy
o First Episode Psychosis community education for early intervention
o First Episode Psychosis new journeys learning event

o Peer certification trainings
o Peer crisis certification trainings
o Peer wellness coach and train the trainer trainings
o Prevention fellowship and apprenticeship programs
o Prevention Training Series:
Community Anti-Drug Coalitions of America Boot Camp
Community Prevention Wellness Initiative Training Series
Health Equity Prevention Services and Training
Substance Abuse Prevention Skills Training
o Relevant conferences with continuing education credits
o Tele-behavioral health training series
o Training Behavioral Health Agency staff to effectively treat mental health conditions for youth that are Autism Spectrum Disorder and Intellectual and Developmental Disabilities
o WAADAC Workforce Summit
o Wellness recovery action plan trainings and facilitator training
o Wraparound with intensive services SMI/SED workforce development trainings

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Monitor campaign landing page traffic, stakeholder feedback, continuing education and training review for content relevance.

Baseline Measurement: StartYourPath.org Campaign state fiscal year 2023 workforce campaign there were: • 19,252,281 Impressions • 1,758,716 Views • 191,494 Landing page sessions

First-year target/outcome measurement: Maintain or increase baseline metrics • 19,252,281 Impressions • 1,758,716 Views • 191,494 Landing page sessions

Second-year target/outcome measurement: Maintain or increase baseline metrics • 19,252,281 Impressions • 1,758,716 Views • 191,494 Landing page sessions

Data Source:

Contractor Reporting

Description of Data:

Campaign impressions and training / conference review metrics

Data issues/caveats that affect outcome measures:

None

Priority #: 13

Priority Area: Increasing access to Behavioral Health Crisis Services (BHCS) through expansion of voluntary mobile crisis services.

Priority Type: SUT, SUR, MHS, BHCS

Population(s): SMI, SED, ESMI, BHCS, PWWDC, PP, PWID, TB

Goal of the priority area:

Increase access to BHCS and improve outcomes for people receiving these services by expanding mobile crisis services. With the designation and routing of 988, the State of Washington has been implementing SAMHSA's best practice toolkit with a focus on expanding mobile crisis services. This started in 2021 with new legislation and funding for more mobile crisis services. These efforts are ongoing.

Strategies to attain the goal:

• Increase the number of mobile crisis teams
• Increase access to stabilization services by improving capacity of teams to provide these services.
• Engage in targeted conversations with Tribes for expansion of Mobile Crisis Teams within Tribal communities.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator:	Maintain and increase number of mobile crisis providers in the state.
Baseline Measurement:	42 mobile crisis teams statewide
First-year target/outcome measurement:	Maintain current statewide number of mobile crisis providers at 42 teams.
Second-year target/outcome measurement:	Increase the statewide number of mobile crisis providers by at least 6 new teams, for a total of 48 teams statewide.

Data Source:

Report on current number of teams and FTE from BH-ASOs

Description of Data:

Data is collected from BH-ASOs through surveys of providers with mobile crisis teams about current FTEs, number of openings, and basic coverage ability.

Data issues/caveats that affect outcome measures:

Workforce challenges, limited ability to predict demand for new and emerging services, and data collection issues.

Priority #:	14
Priority Area:	Increase the number of adults receiving opioid use disorder treatment, support during recovery from OUD, and tools necessary to reduce deaths resulting from opioid overdose and poisoning.
Priority Type:	SUT, SUR
Population(s):	PWWDC, PP, PWID

Goal of the priority area:

Increase accessibility of treatment for individuals experiencing opioid use disorder; support individuals in recovery from opioid use disorder; reduce the harms associated with opioid use and misuse.

Strategies to attain the goal:

• Partner with syringe exchange programs, local agencies, physical health settings, and emergency services to equip lay responders and professionals with overdose response training and naloxone.
• Partner with the University of Washington Addiction, Drug and Alcohol Institute (UW ADAI) to provide training and technical assistance to participating jails to increase the number of incarcerated individuals assessed for OUD, newly prescribed buprenorphine or naltrexone, or continuing treatment for individuals taking MOUD upon booking.
• Improve communication and coordination with referring partners to increase the number of individuals receiving services from the Recovery Navigator Program (RNP) and Law Enforcement Assisted Diversion (LEAD) program.
• Treatment penetration rates

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Increase the number of naloxone kits distributed, individuals trained on naloxone administration, and reported overdose reversals with program kits.
Baseline Measurement:	WA-PDO grant: Between August 31, 2021 and August 30, 2022, 12,494 naloxone kits were distributed, 2,721 individuals were trained on naloxone administration, and 1,957 overdose reversals using program kits were reported. SABG grant: Between October 21, 2021 and September 30, 2022, 31,020 naloxone kits were distributed, 14,129 individuals were trained on naloxone administration, and 5,599 overdose reversals using program kits were reported.
First-year target/outcome measurement:	Increase baseline by 50% to 65,271 Naloxone kits distributed.
Second-year target/outcome measurement:	Increase baseline by 75% to 76,149 Naloxone kits distributed.

Data Source:

Department of Health, Office of Education and Naloxone Distribution (OEND)

Description of Data:

The data includes the number of naloxone kits distributed through OEND with support provided by DOH and HCA. Targets include estimations based on all funding sources, both state and federal.

Data issues/caveats that affect outcome measures:

FY 25 targets could be affected, either increased or decreased, based on legislative appropriations in the 2024 Supplemental budget.

Indicator #: 2

Indicator: Increase the number of incarcerated people newly prescribed buprenorphine or naltrexone and the number of incarcerated people continuing treatment who were taking MOUD upon booking.

Baseline Measurement: Estimates for SFY23: 3,030 incarcerated individuals newly prescribed buprenorphine or naltrexone; 880 incarcerated individuals continuing MOUD treatment.

First-year target/outcome measurement: Increase the number of incarcerated individuals newly prescribed buprenorphine or naltrexone in SFY24 to 3,180. Increase the number of incarcerated individuals continuing MOUD treatment after booking to 920.

Second-year target/outcome measurement: Increase the number of incarcerated individuals newly prescribed buprenorphine or naltrexone in SFY24 to 3,260. Increase the number of incarcerated individuals continuing MOUD treatment after booking in SFY24 to 943.

Data Source:

Programmatic data collected by 19 MOUD in jail programs throughout the state.

Description of Data:

Data collected includes the number of people incarcerated among the 19 programs who are inducted on buprenorphine; and he number of people incarcerated among the 19 programs who were continued on MOUD upon booking.

Data issues/caveats that affect outcome measures:

FY 25 targets could increase or decrease based on whether or not funding level are changes in the 2024 Supplemental Budget.

Indicator #: 3

Indicator: Increase the total number of referrals, follow-ups, and outreaches in the Recovery Navigator Program.

Baseline Measurement: SFY22: 4,603 referrals, 213 follow-ups, and 3,697 outreaches.

First-year target/outcome measurement: Increase the total number of referrals into the RNP in SFY24 by 100% to 9,206; Increase the total number of follow-ups by 100% in SFY2024 to 426; increase the total number of outreaches by 100% in SFY2024 to 7,394

Second-year target/outcome measurement: Maintain the total number of referrals into the RNP in SFY2025 at 9,206 Maintain the total number of follow-ups in SFY2025 at 426 Maintain the total number of outreaches in SFY2025 at 7,394.

Data Source:

Recovery Navigators quarterly data submissions.

Description of Data:

SFY22 is an unduplicated count of adults referred to, followed up with, or otherwise contacted by Recovery Navigators between July 1, 2021 and June 30, 2022.

Data issues/caveats that affect outcome measures:

N/A

Indicator #: 4

Indicator:	Increase opioid use disorder treatment penetration rates.
Baseline Measurement:	SFY19: 52,471 Medicaid beneficiaries had a treatment need, 55% of whom received treatment.
First-year target/outcome measurement:	Increase the percentage of Medicaid beneficiaries receiving needed treatment for OUD in SFY24 to 60%.
Second-year target/outcome measurement:	Increase the percentage of Medicaid beneficiaries receiving needed treatment for OUD in SFY25 to 65%.

Data Source:

Washington State conducted, retrospective (by year), a cross-sectional analyses of Washington State SUD/OUD administrative data to produce a Current State Assessment of the state of SUD/OUD treatment penetration, among other things. All data were drawn from the Department of Social and Health Service's Integrated Client Database (ICDB). The ICDB contains data from several administrative data systems, including the state's ProviderOne data system that contains Medicaid claims and encounter data.

Description of Data:

The population of focus was Medicaid beneficiaries (ages 13-64 years) with behavioral health diagnoses. Medicaid beneficiaries with a non-Medicaid primary health care coverage (also referred to as third-party liability) and those who are dually enrolled in Medicaid and Medicare were excluded from the analyses, as complete health care utilization information may not be available for these individuals. Analyses were further restricted to individuals who met minimum Medicaid enrollment criteria (11 out of 12 months in the measurement year) to meet eligibility requirements for the treatment penetration rate metrics. Medicaid beneficiaries with a SUD or OUD diagnosis are the primary focus of the Current State Assessment.

Data issues/caveats that affect outcome measures:

Current data available only shows FY17 through FY 19. 2019 is the last "non covid" year for which we have data. This analysis is currently being updated with data through FY 2022. This data could reveal unknown changes in treatment penetration that may be caused by the Covid 19 pandemic. This analysis will be available later this year. Once available targets for this indicator may need to be revised.

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Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [SUPTRS]

States must project how the SSA will use available funds to provide authorized services for the planning period for state fiscal years FFY 2024/2025.
SUPTRS BG – ONLY include funds expended by the executive branch agency administering the SUPTRS BG.

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2025

Activity (See instructions for using Row 1.)	Source of Funds									
	A. SUPTRS BG	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. COVID-19 Relief Funds (MHBG)[a]	I. COVID-19 Relief Funds (SUPTRS BG)[a]	J. ARP Funds (SUPTRS BG)[b]
1. Substance Use Prevention[c] and Treatment	$52,021,651.00		$725,968,000.00	$64,175,000.00	$173,946,000.00	$0.00	$0.00		$10,095,712.00	$0.00
a. Pregnant Women and Women with Dependent Children[c]	$4,198,822.00		$15,074,000.00		$10,161,000.00				$367,188.00	
b. Recovery Support Services	$12,688,310.00			$9,891,000.00	$9,700,000.00				$2,751,961.00	
c. All Other	$35,134,519.00		$710,894,000.00	$54,284,000.00	$154,085,000.00				$6,976,563.00	
2. Primary Prevention[d]	$27,755,958.00		$22,611,000.00	$6,352,000.00	$26,690,000.00	$0.00	$0.00		$2,474,841.00	$0.00
a. Substance Use Primary Prevention	$27,755,958.00		$22,611,000.00	$6,352,000.00	$26,690,000.00				$2,474,841.00	
b. Mental Health Prevention										
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)										
4. Other Psychiatric Inpatient Care										
5. Tuberculosis Services	$0.00								$0.00	
6. Early Intervention Services for HIV	$0.00								$0.00	
7. State Hospital										
8. Other 24-Hour Care										
9. Ambulatory/Community Non-24 Hour Care										
10. Crisis Services (5 percent set-aside)										
11. Administration (excluding program/provider level) MHBG and SUPTRS BG must be reported separately	$4,198,821.00		$9,651,000.00	$2,666,000.00	$4,017,000.00				$502,258.00	
12. Total	**$83,976,430.00**	**$0.00**	**$758,230,000.00**	**$73,193,000.00**	**$204,653,000.00**	**$0.00**	**$0.00**	**$0.00**	**$13,072,811.00**	**$28,971,794.00**

[a] The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[b] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. Per the instructions, the planning period for standard MHBG/SUPTRS BG expenditures is July 1, 2023 – June 30, 2025. Please enter SUPTRS BG ARP planned expenditures for the period of July 1, 2023 through June 30, 2025

[c] Prevention other than primary prevention

[d] The 20 percent set-aside funds in the SUPTRS BG must be used for activities designed to prevent substance misuse.

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Footnotes:
Washington plans to spend the remaining balance of SUPTRS COVID-19 funds between July 1, 2023 and March 14, 2024.

Planning Tables

Table 2 State Agency Planned Expenditures [MH]

Table 2 addresses funds to be expended during the 24-month period of July 1, 2023 through June 30, 2025. Table 2 now includes columns to capture state expenditures for COVID-19 Relief Supplemental and ARP funds. Please use these columns to capture how much the state plans to expend over a 24-month period (July 1, 2023 - June 30, 2025). Please document the use of COVID-19 Relief Supplemental and ARP funds in the footnotes.

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2025

Activity (See instructions for using Row 1.)	Source of Funds										
	A. SUPTRS BG	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. COVID-19 Relief Funds (MHBG)[a]	I. COVID-19 Relief Funds (SUPTRS BG)[a]	J. ARP Funds (MHBG)[b]	K. BSCA Funds (MHBG)[c]
1. Substance Use Prevention and Treatment											
a. Pregnant Women and Women with Dependent Children											
b. Recovery Support Services											
c. All Other											
2. Primary Prevention											
a. Substance Use Primary Prevention											
b. Mental Health Prevention[d]		$0.00	$0.00	$0.00	$600,000.00	$0.00	$0.00	$0.00		$0.00	
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)[e]		$7,027,053.00	$0.00	$0.00	$0.00	$0.00	$0.00	$705,968.00		$2,442,388.00	
4. Other Psychiatric Inpatient Care			$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	
5. Tuberculosis Services											
6. Early Intervention Services for HIV											
7. State Hospital			$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	
8. Other 24-Hour Care		$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	
9. Ambulatory/Community Non-24 Hour Care		$35,135,265.00	$3,211,085,000.00	$16,679,000.00	$448,649,000.00	$0.00	$0.00	$6,095,287.00		$15,477,052.00	
10. Crisis Services (5 percent set-aside)[f]		$2,342,351.00	$33,074,000.00	$0.00	$68,933,000.00	$0.00	$0.00	$499,132.00		$2,035,324.00	
11. Administration (excluding program/provider level) MHBG and SUPTRS BG must be reported separately[g]		$2,342,351.00	$36,042,000.00	$834,000.00	$8,066,000.00	$0.00	$0.00	$366,687.00		$1,017,662.00	
12. Total	**$0.00**	**$46,847,020.00**	**$3,280,201,000.00**	**$17,513,000.00**	**$526,248,000.00**	**$0.00**	**$0.00**	**$7,667,074.00**	**$0.00**	**$20,972,426.00**	**$2,723,622.00**

[a]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" MHBG. Columns H should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states. Note: If your state has an approved no cost extension, you have until March 14, 2024, to expend the COVID-19 Relief supplemental funds.

[b]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" MHBG. Columns H should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states.

[c]The expenditure period for the 1st allocation of Bipartisan Safer Communities Act (BSCA) supplemental funding is from **October 17, 2022 thru October 16, 2024** and the expenditure for the 2nd allocation of BSCA funding will be from September 30, 2023 thru September 29, 2025 which is different from the expenditure period for the "standard" MHBG. Column J should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states.

[d]While the state may use state or other funding for prevention services, the MHBG funds must be directed toward adults with SMI or children with SED.

[e]Column 3 should include Early Serious Mental Illness programs funded through MHBG set aside.

[f]Row 10 should include Behavioral Health Crisis Services (BHCS) programs funded through different funding sources, including the MHBG set aside. States may expend more than 5 percent of their MHBG allocation.

[g]Per statute, administrative expenditures cannot exceed 5% of the fiscal year award.

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Footnotes:

Covid-19 funding amounts in column H reflect remaining balances on projects planned through March 14, 2024.
ARPA funding amounts in column J reflect planned expenditures for projects between July 1, 2023-June 30, 2025.
BSCA funding amounts in column K reflect planned expenditures for both round 1 and round 2 BSCA awards between July 1, 2023 and June 30, 2025.

Planning Tables

Table 3 SUPTRS BG Persons in need/receipt of SUD treatment

To complete the Aggregate Number Estimated in Need column, please refer to the most recent edition of SAMHSA's National Survey on Drug Use and Health (NSDUH) or other federal/state data that describes the populations of focus in rows 1-5.

To complete the Aggregate Number in Treatment column, please refer to the most recent edition of the Treatment Episode Data Set (TEDS) data prepared and submitted to SAMHSA's Behavioral Health Services Information System (BHSIS).

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
1. Pregnant Women	13,629	4,379
2. Women with Dependent Children	30,056	12,382
3. Individuals with a co-occurring M/SUD	181,315	64,522
4. Persons who inject drugs	0	5,050
5. Persons experiencing homelessness	61,769	26,351

Please provide an explanation for any data cells for which the state does not have a data source.

DSHS Research and Data Analysis Division's Integrated Client Databases do not contain data for persons who inject drugs, so data from BHDS was used for the numbers served. There is no current methodology to estimate the number of PWID with a SUD treatment need. If SAMHSA is able to provide TA on this we would appreciate it.

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Footnotes:

Planning Tables

Table 4 SUPTRS BG Planned Expenditures

States must project how they will use SUPTRS BG funds to provide authorized services as required by the SUPTRS BG regulations, including the supplemental COVID-19 and ARP funds. Plan Table 4 must be completed for the FFY 2024 and FFY 2025 SUPTRS BG awards. The totals for each Fiscal Year should match the President's Budget Allotment for the state.

Planning Period Start Date: 10/1/2023   Planning Period End Date: 9/30/2024

	FFY 2024		
Expenditure Category	**FFY 2024 SUPTRS BG Award**	**COVID-19 Award[1]**	**ARP Award[2]**
1 . Substance Use Disorder Prevention and Treatment[3]	$19,666,670.00	$7,343,751.00	$13,258,391.00
2 . Substance Use Primary Prevention	$13,877,979.00	$2,474,841.00	$7,602,795.00
3 . Early Intervention Services for HIV[4]	$0.00	$0.00	$0.00
4 . Tuberculosis Services	$0.00	$0.00	$0.00
5 . Recovery Support Services[5]	$6,344,155.00	$2,751,961.00	$6,581,287.00
6 . Administration (SSA Level Only)	$2,099,411.00	$502,258.00	$1,529,321.00
7. Total	**$41,988,215.00**	**$13,072,811.00**	**$28,971,794.00**

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19

Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the FY 2024 "standard" SUPTRS BG, which is October 1, 2023 - September 30, 2024. The SUPTRS BG ARP planned expenditures for the period of October 1, 2023 - September 30, 2024 should be entered here in the first ARP column, and the SUPTRS BG ARP planned expenditures for the period of October 1, 2024, through September 30, 2025, should be entered in the second ARP column.

[3]Prevention other than Primary Prevention

[4]For the purpose of determining which states and jurisdictions are considered "designated states" as described in section 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 45 CFR § 96.128(b) of the Substance use disorder Prevention and Treatment Block Grant (SUPTRS BG); Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the AtlasPlus HIV data report produced by the Centers for Disease Control and Prevention (CDC,), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention (NCHHSTP). The most recent AtlasPlus HIV data report published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective SUPTRS BG allotments to establish one or more projects to provide early intervention services regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a “designated state” in any of the three years prior to the year for which a state is applying for SUPTRS BG funds with the flexibility to obligate and expend SUPTRS BG funds for EIS/HIV even though the state’s AIDS case rate does not meet the AIDS case rate threshold for the fiscal year involved for which a state is applying for SUPTRS BG funds. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance will be allowed to obligate and expend SUPTRS BG funds for EIS/HIV if they chose to do so and may elect to do so by providing written notification to the CSAT SPO as a part of the SUPTRS BG Application.

[5]This expenditure category is mandated by Section 1243 of the Consolidated Appropriations Act, 2023.

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Footnotes:

Planning Tables

Table 5a SUPTRS BG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

Strategy	IOM Target	FFY 2024		
		SUPTRS BG Award	COVID-19 Award[1]	ARP Award[2]
1. Information Dissemination	Universal	$2,459,136	$7,825	$416,237
	Selected	$0	$0	$0
	Indicated	$0	$0	$0
	Unspecified	$0	$0	$0
	Total	**$2,459,136**	**$7,825**	**$416,237**
2. Education	Universal	$1,036,928	$14,330	$245,928
	Selected	$361,856	$1,634	$87,583
	Indicated	$1,207	$0	$256
	Unspecified	$0	$0	$0
	Total	**$1,399,991**	**$15,964**	**$333,767**
3. Alternatives	Universal	$85,061	$100,000	$118,044
	Selected	$7,953	$0	$1,687
	Indicated	$0	$0	$0
	Unspecified	$0	$0	$0
	Total	**$93,014**	**$100,000**	**$119,731**
4. Problem Identification and Referral	Universal	$7,612	$0	$1,878
	Selected	$2,200,325	$0	$542,896
	Indicated	$169,393	$0	$141,795
	Unspecified	$0	$0	$0
	Total	**$2,377,330**	**$0**	**$686,569**
	Universal	$5,412,311	$732,864	$1,166,207

5. Community-Based Processes	Selected	$0	$0	$0
	Indicated	$55,677	$0	$13,738
	Unspecified	$0	$0	$0
	Total	**$5,467,988**	**$732,864**	**$1,179,945**
6. Environmental	Universal	$21,964	$4,570	$4,659
	Selected	$0	$0	$0
	Indicated	$0	$0	$0
	Unspecified	$0	$0	$0
	Total	**$21,964**	**$4,570**	**$4,659**
7. Section 1926 (Synar)-Tobacco	Universal	$0	$0	$0
	Selected	$0	$0	$0
	Indicated	$0	$0	$0
	Unspecified	$0	$0	$0
	Total	**$0**	**$0**	**$0**
8. Other	Universal	$451,102	$18,776	$101,945
	Selected	$656	$0	$139
	Indicated	$0	$0	$0
	Unspecified	$0	$0	$0
	Total	**$451,758**	**$18,776**	**$102,084**
Total Prevention Expenditures		**$12,271,181**	**$879,999**	**$2,842,992**
Total SUPTRS BG Award[3]		**$41,988,215**	**$13,072,811**	**$28,971,794**
Planned Primary Prevention Percentage		**29.23 %**	**6.73 %**	**9.81 %**

[1]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 1, 2025**, which is different from the expenditure period for the "standard" SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the planned expenditure period of October 1, 2023 – September 30, 2025.

[3]Total SUPTRS BG Award is populated from Table 4 - SUPTRS BG Planned Expenditures

Footnotes:

Planning Tables

Table 5b SUPTRS BG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

Activity	FFY 2024 SUPTRS BG Award	FFY 2024 COVID-19 Award[1]	FFY 2024 ARP Award[2]
Universal Direct	$7,384,087	$865,882	$1,729,310
Universal Indirect	$2,090,026	$12,484	$325,588
Selected	$2,570,790	$1,634	$632,306
Indicated	$226,278	$0	$155,789
Column Total	**$12,271,181**	**$880,000**	**$2,842,993**
Total SUPTRS BG Award[3]	**$41,988,215**	**$13,072,811**	**$28,971,794**
Planned Primary Prevention Percentage	**29.23 %**	**6.73 %**	**9.81 %**

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the “standard” MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 1, 2025**, which is different from the expenditure period for the “standard” SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the planned expenditure period of October 1, 2023 – September 30, 2025.

[3]Total SUPTRS BG Award is populated from Table 4 - SUPTRS BG Planned Expenditures

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Planning Tables

Table 5c SUPTRS BG Planned Primary Prevention Priorities (Required)

States should identify the categories of substances the state BG plans to target with primary prevention set-aside dollars from the FFY 2024 and FFY 2025 SUPTRS BG awards.

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

	SUPTRS BG Award	COVID-19 Award[1]	ARP Award[2]
Prioritized Substances			
Alcohol	☑	☑	☑
Tobacco	☑	☑	☑
Marijuana	☑	☑	☑
Prescription Drugs	☑	☑	☑
Cocaine	☑	☑	☑
Heroin	☑	☑	☑
Inhalants	☑	☑	☑
Methamphetamine	☑	☑	☑
Fentanyl	☑	☑	☑
Prioritized Populations			
Students in College	☑	☑	☑
Military Families	☑	☑	☑
LGBTQI+	☑	☑	☑
American Indians/Alaska Natives	☑	☑	☑
African American	☑	☑	☑
Hispanic	☑	☑	☑
Persons Experiencing Homelessness	☑	☑	☑
Native Hawaiian/Other Pacific Islanders	☑	☑	☑
Asian	☑	☑	☑
Rural	☑	☑	☑

Underserved Racial and Ethnic Minorities			

[1]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 1, 2025**, which is different from the expenditure period for the "standard" SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the planned expenditure period of October 1, 2023 – September 30, 2025.

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Planning Tables

Table 6 Non-Direct-Services/System Development [SUPTRS]

Please enter the total amount of the SUPTRS BG, COVID-19, or ARP funds expended for each activity.

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

Expenditure Category	FFY 2024				
	A. SUPTRS BG Treatment	B. SUPTRS BG Prevention	C. SUPTRS BG Integrated[1]	D. COVID-19[2]	E. ARP[3]
1. Information Systems	$536,413.00	$432,071.00	$0.00	$151,350.00	$200,000.00
2. Infrastructure Support	$2,156,604.00	$0.00	$0.00	$92,363.00	$10,000.00
3. Partnerships, community outreach, and needs assessment	$2,780,876.00	$322,392.00	$0.00	$2,293,562.00	$6,881,412.00
4. Planning Council Activities (MHBG required, SUPTRS BG optional)	$0.00	$0.00	$0.00	$0.00	$0.00
5. Quality Assurance and Improvement	$175,000.00	$0.00	$0.00	$0.00	$0.00
6. Research and Evaluation	$658,166.00	$518,419.00	$0.00	$343,750.00	$0.00
7. Training and Education	$1,216,500.00	$333,916.00	$0.00	$468,157.00	$0.00
8. Total	**$7,523,559.00**	**$1,606,798.00**	**$0.00**	**$3,349,182.00**	**$7,091,412.00**

[1]Integrated refers to non-direct service/system development expenditures that support both treatment and prevention systems of care.

[2]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[3]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the federal planned expenditure period of October 1, 2023 - September 30, 2025. Please list ARP planned expenditures for each standard FFY period.

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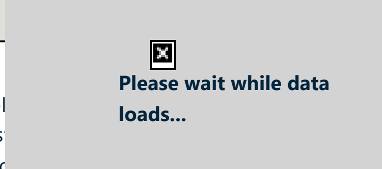
Planning Tables

Table 6 Non-Direct-Services/System Development [MH]

Please enter the total amount of the MHBG, COVID-19, ARP funds, and BSCA funds expended for each activity

MHBG Planning Period Start Date: MHBG Planning Period End Date:

Activity	FY Block Grant	FY [1] COVID Funds	FY [2] ARP Funds	FY [3] BSCA Funds
.	$	$	$	$
8. Total	**$**	**$**	**$**	**$**



[1] The 24-month expenditure period for the COVID-19 Rel...21 - **March 14, 2023**, which is different from the expenditure period for the "standard" MHBG. Per the ins...res captured in Columns A - G are for the state planned expenditure period of July 1, 2023 - June 30, 2025, for mo...oved no cost extension, you have until March 14, 2024 to expend the COVID-19 Relief supplemental funds.

[2] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" MHBG. Per the instructions, the standard MHBG expenditures captured in Columns A - G are for the state planned expenditure period of July 1, 2023 - June 30, 2025, for most states.

[3] The expenditure period for the 1st allocation of Bipartisan Safer Communities Act (BSCA) supplemental funding is **October 17, 2022** thru **October 16, 2024** and for the 2nd allocation will be **September 30, 2023** thru **September 29, 2025** which is different from the expenditure period for the "standard" MHBG. Column D should reflect the spending for the state reporting period. The total may reflect the BSCA allotment portion used during the state reporting period.

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Environmental Factors and Plan

1. Access to Care, Integration, and Care Coordination – Required

Narrative Question

Across the United States, significant percentages of adults with serious mental illness, children and youth with serious emotional disturbances, and people with substance use disorders do not access needed behavioral health care. States should focus on improving the range and quality of available services and on improving the rate at which individuals who need care access it. States have a number of opportunities to improve access, including improving capacity to identify and address behavioral needs in primary care, increasing outreach and screening in a variety of community settings, building behavioral health workforce and service system capacity, and efforts to improve public awareness around the importance of behavioral health. When considering access to care, states should examine whether people are connected to services, and whether they are receiving the range of needed treatment and supports.

A venue for states to advance access to care is by ensuring that protections afforded by MHPAEA are being adhered to in private and public sector health plans, and that providers and people receiving services are aware of parity protections. SSAs and SMHAs can partner with their state departments of insurance and Medicaid agencies to support parity enforcement efforts and to boost awareness around parity protections within the behavioral health field. The following resources may be helpful: **https://store.samhsa.gov/product/essential-aspects-of-parity-training-tool-for-policymakers/pep21-05-00-001**; **https://store.samhsa.gov/product/Approaches-in-Implementing-the-Mental-Health-Parity-and-Addiction-Equity-Act-Best-Practices-from-the-States/SMA16-4983**. The integration of primary and behavioral health care remains a priority across the country to ensure that people receive care that addresses their mental health, substance use, and physical health problems. People with mental illness and/or substance use disorders are likely to die earlier than those who do not have these conditions.[1]Ensuring access to physical and behavioral health care is important to address the physical health disparities they experience and to ensure that they receive needed behavioral health care. States should support integrated care delivery in specialty behavioral health care settings as well as primary care settings. States have a number of options to finance the integration of primary and behavioral health care, including programs supported through Medicaid managed care, Medicaid health homes, specialized plans for individuals who are dually eligible for Medicaid and Medicare, and prioritized initiatives through the mental health and substance use block grants or general funds. States may also work to advance specific models shown to improve care in primary care settings, including Primary Care Medical Homes; the Coordinated Care Model; and Screening, Brief Intervention, and Referral to Treatment.

Navigating behavioral health, physical health, and other support systems is complicated and many individuals and families require care coordination to ensure that they receive necessary supports in and efficient and effective manner. States should develop systems that vary the intensity of care coordination support based on the severity seriousness and complexity of individual need. States also need to consider different models of care coordination for different groups, such as High-Fidelity Wraparound and Systems of Care when working with children, youth, and families; providing Assertive Community Treatment to people with serious mental illness who are at a high risk of institutional placement; and connecting people in recovery from substance use disorders with a range of recovery supports. States should also provide the care coordination necessary to connect people with mental and substance use disorders to needed supports in areas like education, employment, and housing.

[1]Druss, B. G., Zhao, L., Von Esenwein, S., Morrato, E. H., & Marcus, S. C. (2011). Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Medical care, 599-604.Avaiable at: **https://journals.lww.com/lww-medicalcare/Fulltext/2011/06000/Understanding_Excess_Mortality_in_Persons_With.11.aspx**

1. Describe your state's efforts to improve access to care for mental disorders, substance use disorders, and co-occurring disorders, including detail on efforts to increase access to services for:

a) Adults with serious mental illness

b) Pregnant women with substance use disorders

c) Women with substance use disorders who have dependent children

d) Persons who inject drugs

e) Persons with substance use disorders who have, or are at risk for, HIV or TB

f) Persons with substance use disorders in the justice system

g) Persons using substances who are at risk for overdose or suicide

h) Other adults with substance use disorders

i) Children and youth with serious emotional disturbances or substance use disorders

j) Individuals with co-occurring mental and substance use disorders

a) Adults with serious mental illness

Since 2016, the state has been integrating the purchasing of physical and behavioral health services through its Managed Care (Apple Health) Plans. Under integrated managed care, services are coordinated through a single health plan, including physical health, mental health, and substance use disorder (SUD) treatment. Now, the state is focusing on clinical integration and implementing a statewide, standardized assessment that will also serve as an integration roadmap for practices and providers. This will further:

• Support whole-person care by creating one system for physical and behavioral health care, rather than having separate systems.
• Improve provider communication and reduce unnecessary duplication of services.
• Expand access to behavioral health to include mental health and SUD treatment.
• Link clients with critical community services, such as housing and employment support.

The standardized assessment is called the WA-ICA, which will help providers/practices track, measure, and advance their efforts in advancing clinical integration in Washington State. It will also establish a common language and approach to integration and help stakeholders identify where funding and policy support is needed.

Initially the assessment is voluntary but will ultimately be required for outpatient primary care and behavioral health providers who provide services to Apple Health enrollees. The assessment will assist practices with understanding their level of integration and help identify next steps along the integration continuum. Practices will be eligible for coaching support and technical assistance to help them make progress on integration.

b) Pregnant women with substance use disorders

Washington Medicaid Managed Care Plans are each responsible for care coordination and connection to services for their members.

Additionally, Washington is working to create options for Pregnant and Parenting Individuals through several pathways to build upon our existing PPW treatment network. Our legislature funded an additional Pregnant and Parenting Residential Substance Use Disorder Residential Treatment Facility with direction to build it within the framework of family preservation
The work is underway with our SUD providers, our Medicaid office, Dept. Of Health, and Dept. Of Child Welfare to create a shared understanding of what 'Family Preservation' is and what it will take to support providers standing up a Substance Use Disorder Treatment Facility using a Family Preservation Model. Washington is also exploring and supporting what's known as a 'Rising Strong' model that will be modeled from a housing foundation and have services and supports of a residential model available to Pregnant Parenting Individuals to support the ongoing safe and stable housing need.

We anticipate using the Family Preservation Model work funded for the Substance Use Disorder Residential Treatment Facility, to inform shifts throughout the continuum of care for Pregnant and Parenting Individuals and their Dependent Children, attending treatment with their Parent(s). MOUD and support for other medical based supports are also core elements of this work.

c) Women with Substance Use Disorders who have Dependent Children

Washington is working to create options for Pregnant and Parenting Individuals through several pathways to build upon our existing PPW treatment network. Our legislature funded an additional Pregnant and Parenting Substance Use Disorder Residential Treatment Facility with direction to build it within the framework of family preservation
The work is underway with our SUD providers, our Medicaid office, Dept. Of Health, and Dept. Of Child Welfare to create a shared understanding of what 'Family Preservation' is and what it will take to support providers standing up a Substance Use Disorder Treatment Facility using a Family Preservation Model. Washington is also exploring and supporting what's known as a 'Rising Strong' model that will be modeled from a housing foundation and have services and supports of a residential model available to Pregnant Parenting Individuals to support the ongoing safe and stable housing need.

These models are both exploring the needs of families working toward and participation in dependency and/ or reunification.

d) Persons who inject drugs

Syringe services programs (SSPs) are well known for their success in engaging people who use drugs (PWUD), especially those who inject or smoke opioids and/or stimulants, by providing safer drug use equipment to prevent infection and disease transmission. Most SSPs also provide additional health services including onsite testing (and, in some cases, treatment) for HIV and viral hepatitis, vaccinations, reproductive health resources, and referrals or direct linkage to health and social services, including substance use treatment. Most recently, many SSPs now also offer onsite access to buprenorphine to treat opioid use disorder (OUD). Other harm reduction programs with similar services include day service programs for those who are unhoused and community health clinics with an overt harm reduction mission.

In 2019, Washington State Health Care Authority began a contract with University of Washington- Addictions, Drug & Alcohol Institute (ADAI) to support the community-Based "Meds First" program, now called the Nurse Care Manager program, to provide onsite, low-barrier access to buprenorphine in partnership with six harm reduction programs (HRPs) across Washington State. A key component of the service model was the addition of care navigation to support client engagement and retention in OUD

treatment. While care navigation is commonly used in health care, substance use treatment, housing, and mental health settings, it is rarely funded and available at Syring SSPs and other HRPs.

The Community Meds First model of care is defined by these essential characteristics:

• Service provided within or adjacent to syringe services programs/harm reduction programs.
• Care team with a prescriber, nurse care manager, and at least one care navigator.
• Walk-in, same-day access to buprenorphine.
• Six months of follow-up care as a bridge to longer-term OUD treatment, onsite or in the community.
• Ongoing substance use seen as an opportunity for further engagement, not as treatment failure or reason for discharge.
• Shared decision making for medications for opioid use disorder.
• Counseling offered but not mandated.

Intravenous drug users are also priority populations for the Nurse Care Manager project, which is a state-funded project which aims to increase access to medication for opioid use disorder services. The only eligibility requirements for the individual to receive care through this project they must meet the Diagnostic and Statistical Manual of Mental Disorders (DSM 5) diagnostic criteria for opioid use disorder (OUD) and meet state and federal eligibility requirements for admission.

e) Persons with substance use disorders who have, or are at risk for, HIV or TB

Washington State Rules have various requirements for behavioral health agencies (BHA) to document screening and referrals related to infectious disease. Personnel who work at BHAs, that provide substance use disorder (SUD) services, require staff orientation and annual training related to prevention and control of communicable disease, bloodborne pathogens, and tuberculosis. Similar training is required for the multi-disciplinary staff at Withdrawal Management facilities, where training for individuals providing direct care are required to complete training on infectious diseases, to include hepatitis and tuberculosis. In addition, Washington State Opioid Treatment Programs (OTP) are required, through Washington Administrative Code, to provide educational materials covering infectious diseases, sexually transmitted infections, and tuberculosis to everyone admitted.

Since 2020, the State Opioid Response Opioid Treatment Networks and Hub & Spokes provide HIV and viral Hepatitis screening, referrals and/or treatment to individuals with Opioid Use Disorder (OUD) or co-occurring OUD. Of the individuals provided medications for opioid use disorder in 2022, 8,057 were provided testing and referrals for HIV treatment and 6,708 were provided testing and referrals for viral Hepatitis. These programs work within their organizations, subcontracted or community partners to provide these services. They are also encouraged to coordinate and collaborate with the Ryan White HIV/AIDS Program (RWHAP) which provides a comprehensive system of care including medical care and support services for people living HIV who are uninsured or underinsured.

f) Persons with substance use disorders in the justice system

The Criminal Justice Treatment Account is a state proviso-funded resource that distributes funding to BHASOs and counties throughout the State of WA to pay for substance use treatment for participants of therapeutic courts (drug, juvenile, etc.) with the intention of supporting recovery in place of simply relying on incarceration to address substance use of concern. To be eligible, one simply needs to be charged with a crime and present with substance use that does or has the potential to lead to a state wherein it would be a diagnosable disorder. Funds support administrative costs, innovative/best practice implementation, treatment options spanning a comprehensive spectrum in terms of intensity, and a flexible variety of recovery supports (housing, clothing, childcare, transportation, education, job training, etc.).

Since 2018, the participating State Opioid Response Opioid Treatment Network (OTN) jails have been responsible for inducting individuals with Opioid Use Disorder onto MOUD, screening and referring for re-entry services, eliminating barriers to recovery resources upon release, and providing overdose prevention education and naloxone kits. The OTN jails focus on establishing strong relationships with community and network partners to ensure individual recovery success. There are currently four in Washington state located at the Benton County Jail, Franklin County Jail, Kitsap County Jail, and SCORE Jail.

According to a recent survey of Washington state jails, approximately sixty percent of those incarcerated have known or suspected substance use disorders (SUD) including opioid use disorder (OUD) at intake. The high prevalence of OUD among incarcerated individuals can lead to increased risk of early death, hepatitis C and HIV. Untreated OUD perpetuates the cycle of incarceration, making it highly likely that individuals who use opioids will circulate back through the correctional system. The MOUD in jails program provides incarcerated individuals the opportunity for an OUD assessment, OUD medication, sustained treatment throughout incarceration and connection to continue treatment upon release or transfer. Overall benefits may include reduction in morbidity and mortality due to overdose, reduced re-offenses, reduced complications during withdrawal, improved jail staff safety, cost savings, reduced transfers to emergency departments, custodial costs, and overall improved relationships. The MOUD in Jails Program provides the following:

• Opioid Use Disorder Screening, Clinical Opioid Withdrawal Scale (COWS)
• MOUD continuation or induction: offer all three FDA approved medications; buprenorphine, naltrexone and methadone when an OTP is available.
• Screen for and support acute withdrawal
• Reentry coordination/transition Services
• Naloxone and release kits

• Staffing: medical, case management, SUDP, peer specialists, and correctional officers

The MOUD in jails program, Criminal Justice Treatment Account, and the State Opioid Response, Opioid Treatment Network programs in Jail contribute to the Washington State Opioid and Overdose Response Plan under goal 2 by expanding low-barrier access to MOUD in state jails (2.2.1), providing alternative funding to address the Medicaid gap for incarcerated individuals (2.2.10), and expanding access to and utilization of behavioral health services, including opioid use disorder medications in the criminal legal system, and improve effectiveness and coordination of jail re-entry services across the state (strategy 2.4).

g) Persons using substances who are at risk for overdose or suicide

The Washington State Health Care Authority (HCA) has been working with the Washington State Department of Health (DOH) since 2018 contracting various funding sources received by HCA to DOH.

Initially HCA was instructed by the Washington State Legislature to use funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) Substance Abuse Block Grant (SABG) to fund naloxone distribution across the state and was the inception of the Overdose Education and Naloxone Distribution (OEND) section at DOH. DOH provides overdose response training and distributing naloxone through syringe exchange programs, local agencies, physical health settings, and emergency services. Activities engage professional, first responders, local and regional stakeholders, and health care providers to reduce overdose risk and deaths among people who use heroin and prescription opioids. Per the Naloxone Distribution Plan, DOH has taken the lead on naloxone distribution and overdose response training. This program funded by SAMHSA SABG is one of the strategies developed by the State Opioid Overdose Response Plan under the authority of Executive Order 16-109 with the purpose of preventing opioid overdose and deaths from opioid overdose, and building local infrastructure to plan, implement, evaluate, and fund overdose prevention efforts in the long-term. The objectives are:

1. Equip lay responders and professionals with overdose response training/naloxone through access at local agencies/ entities;
2. Educate health care providers, local agencies, syringe exchange programs, and emergency services on opioid guidelines, patient overdose education, opioid use disorders, and naloxone distribution; and
3. Build and harmonize data infrastructures to inform resource allocation, maintain overdose surveillance, and measure outcomes;
4. Make sure there is not overlap of naloxone distribution between this program and the WA-PDO program; and
5. Work closely with HCA DBHR to develop a sustainability plan, to include funding, in preparation for the WA-PDO grant expiring in August 2026.

Secondly, HCA contracts funding from the SAMHSA Washington State Project to Prevent Prescription Drug/Opioid Overdose (WA-PDO). This funding began on August 31, 2021, and is part of a five-year grant specific to overdose prevention. The WA-PDO is a statewide network of organizations mobilizing communities, providing overdose response training, and distributing naloxone through syringe exchange programs in five high-need areas (HNAs). Activities engage professional, first responders, pharmacies, local and regional stakeholders, health care providers, and lay responders to reduce overdose risk and deaths among people who use heroin and prescription opioids. The purpose is preventing opioid overdose and deaths from opioid overdose, and building local infrastructure to plan, implement, evaluate, and fund overdose prevention efforts in the long-term. The objectives are:

1. Develop overdose prevention strategic plans in five HNAs;
2. Equip law enforcement with overdose response training/naloxone;
3. Equip lay responders (LR) with overdose response training/naloxone;
4. Increase naloxone dispensed by pharmacists each year;
5. Educate health care providers on opioid guidelines, patient overdose education, and naloxone and opioid use disorders;
6. Develop new models of substance use treatment linkage and care coordination in five HNAs;
7. Facilitate coordination in five HNAs among local and regional stakeholders and with state agencies;
8. Build and harmonize data infrastructures to inform resource allocation, maintain overdose surveillance, and measure outcomes; and
9. Create knowledge translation infrastructure to disseminate emerging data, best practices, training, and technical assistance.

HCA is also evaluating options for creating and maintaining a bulk purchasing and distribution program for opioid reversal medications as directed by Second Substitute Senate Bill (2SSB) 5195 (2021). Given the state of the opioid epidemic, Washington State needs new strategies to address increasing drug-caused deaths involving opioids. This bill directs state agencies to act in improving access to opioid reversal medications, including establishing a bulk purchasing and distribution program. To create this program, HCA has identified external stakeholders who can help provide input and perspective to HCA about how to successfully create and maintain such an initiative. HCA has contracted with the Center for Evidence-based Policy (CEbP) at Oregon Health and Science University (OHSU) to continue exploring policy and program considerations for HCA to evaluate. HCA is also hiring staff to help support the management of this program and to leverage data from the Washington State All-Payer Claims Database (WA-APCD) to better understand the landscape of naloxone use in Washington.

h) Other adults with substance use disorders

Washington State Health Care Authority weaves various funding streams to ensure a full continuum of substance use disorder services are available for the adult population. Many of these programs are low-barrier and focus on initial engagement that focuses on principles of harm reduction and medication-first ideology. The SUD outpatient and treatment services are designed to meet the needs of the individual. Level of care is established using the American Society of Addiction Medicine (ASAM) standards

and varies depending on the severity of the disorder and the needs of the individual. Addressing underlying reasons for problematic substance use and creating relapse prevention strategies remain the primary foci of SUD counseling.

The continuum of care includes activities designed to engage and connect individuals to recovery services, such as outreach, screening in primary health care or other nonbehavioral health treatment settings, and case management services. One example of a low-barrier program, which engages individuals along the continuum of care, is our State Hub and Spoke (H&S) project.

The H&S model was designed to create a coordinated, systemic response to the complex issues of opioid addiction among Medicaid and low-income populations, focusing specifically on medication for individuals with Opioid Use Disorder (OUD). The hub sites are the primary organization of the project and recipient of funding for the development of the overall project development. The hub sites identify, collaborate, and subcontract with spoke sites to provide integrated care, regardless of how participants enter the system.

Spokes are facilities that provide OUD treatment, behavioral health treatment and/or primary healthcare services, syringe exchange programs, criminal justice programs including jails, and/or wraparound services and referrals. While there has been less movement of patients across the hub and spokes than initially anticipated, the spokes are used as referral sources as needed. Each H&S network is staffed with nurse care managers and care navigators to reduce barriers for individuals seeking services and to help prescribing practitioners manage increases in their practice.

Strategies and interventions will include Evidence Based/Evidence Informed Practices. Project goals are to increase the number of patients receiving medication for opioid use disorder by increasing capacity in a variety of settings and to enhance the integrated care that patients receive, improve retention rates for enrollees, decrease drug and alcohol use, decrease overdoses, and reduce adverse outcomes related to OUD.

i) Children and youth with serious emotional disturbances or substance use disorders

WA legislature invested in standing up youth behavioral health navigators - also known as Kids Mental Health WA which funds regions to stand up region wide networks to work towards their regions needs for the population including mental health, SUD and co-occurring ASD/IDD and Mental health. The regional teams then hold multidisciplinary meetings with specific youth and families seeking support in accessing care that meets their needs, pulling in partners from the network to meet the need, or support the youth and family until access becomes available. Legislature funded a rollout from 2023-2025 - and all regions across the state are participating in the learning collaboratives to support newer regions learning from regions that have stood up networks and multi-disciplinary teams.

Additionally, Washington state continues to build capacity in our Wraparound with Intensive Services (WISe) program through partnerships with youth peer organizations, cultural adaptations in partnership with our Tribes and BIPOC community leaders, and piloting two sites where Applied Behavioral Analysis (ABA) is the intensive service.

Lastly, Washington is deeply invested in expanding access to our Specialty care program for First Episode Psychosis - New Journeys through inclusion in our Medicaid rates toward the goals set by our legislature to have access across Washington based on prevalence and population.

j) Individuals with co-occurring mental and substance use disorders

All of the programs that are currently coordinated out of HCA-Division of Behavioral Health and Recovery assume and understand that this population experiences a high rate of co-occurring mental and physical health disorders, along with substance use disorders. Many of the state and federally funded programs include multi-disciplinary teams which consist of licensed mental health professionals, peers, medical providers, and substance use disorder professionals. An example of one of these programs is the Homeless Outreach Stabilization Transition Project. The Homeless Outreach Stabilization and Transition (HOST) program provides outreach-based treatment services to individuals with serious behavioral health challenges including substance use disorder (SUD). Multidisciplinary teams can provide SUD, medical, rehabilitative, and peer services in the field to individuals who lack consistent access to these vital services. HOST eligibility means that an individual has a behavioral health challenge, which can include SUD with or without co-occurring mental illness, that is untreated, under-treated or undiagnosed, and is experiencing literal or chronic homelessness. HOST eligible individuals will also be experiencing behavioral health symptoms that create a barrier to accessing and receiving conventional behavioral health services and outreach models.

2. Describe your efforts, alone or in partnership with your state's department of insurance and/or Medicaid system, to advance parity enforcement and increase awareness of parity protections among the public and across the behavioral and general health care fields.

The Health Care Authority, the Single State Authority for Substance Use, Mental Health and Medicaid, adheres to the Mental Health Parity and Addiction Equity Act enacted in 2008 requiring MCOs to provide coverage for mental health conditions, including substance use disorders, to be no more restrictive than insurance coverage for other medical conditions. The parity efforts are monitored by an internal HCA workgroup who meet quarterly to increase awareness as needed. MCOs are evaluated for parity compliance within the following domains: Inpatient, in-network, Inpatient, out of network, Outpatient, in network, Outpatient, out-of-network, emergency care, and prescription medications. A comprehensive parity report is generated by the HCA workgroup every three years. The most recent inquiries into the MCOs and workgroup report indicated that there were no current concerns with parity expectations.

3. Describe how the state supports integrated behavioral health and primary health care, including services for individuals with mental disorders, substance use disorders, and co-occurring mental and substance use disorders. Include detail about:

a) Access to behavioral health care facilitated through primary care providers

b) Efforts to improve behavioral health care provided by primary care providers

c) Efforts to integrate primary care into behavioral health settings

a) Access to behavioral health care facilitated through primary care providers

Over the last several years, key efforts have been underway to support and/or bolster access to behavioral health care in primary care settings, to include:

• Multi-payer Primary Care Transformation Model – In collaboration with the state's purchasers, payers, and primary care provider community, HCA has been working to develop a new primary care transformation model (PCTM) for the state. This work strives to promote and incentivize integrated, whole-person, and team-based care. Develop high-functioning accountable care teams that address the goals and needs of the individual and family by efficiently organizing and coordinating care across the range of health system partners, inclusive of behavioral health. More information can be found on our website at https://www.hca.wa.gov/about-hca/programs-and-initiatives/value-based-purchasing/multi-payer-primary-care-transformation-model.
• Collaborative Care Model – Legislation was passed in 2017, Senate Bill 5779, that triggered the implementation of the Collaborative Care Model. The Collaborative Care Model (CoCM) is a model of behavioral health integration that enhances "usual" primary care by adding two key services: care management support for clients receiving behavioral health treatment, and regular psychiatric or board-certified addiction medicine consultation with the primary care team, particularly regarding clients whose conditions are not improving. To support the CoCM model, HCA completed a state plan amendment to add this into the Medicaid benefit. Further guidance and support is provided through the physician related services billing guide, which supports primary care providers in implementation and understanding reimbursement for this team-based model and approach. Additionally, at the prompting of stakeholder engagement, HCA expanded reimbursement options by adding health and behavior codes to the billing guides. More information can be found in our billing guide, at https://www.hca.wa.gov/assets/billers-and-providers/Physician-related-services-bg-20230701.pdf.
• Ensuring robust telehealth policies for all disciplines – Even prior to the public health emergency, HCA had a robust telehealth policy. However, since the pandemic, our policies have significantly expanded to ensure payment parity, as well as allowing for audio only services for established clients. These efforts, in concert with the Department of Commerce work around expanding broadband internet connection to rural and frontier regions, has bolstered access options for all of our physical health and behavioral health services across our state.

b) Efforts to improve behavioral health care provided by primary care providers

As stated above, both the work on the Washington Integrated Care Assessment (WA-ICA) tool and the Primary Care Transformation Model strives to help primary care practices increase, strengthen, and improve clinical integration and team-based models. Those that participate in the WA-ICA receive technical assistance, inclusive of education and tools for primary care practices to better address common conditions such as anxiety and depression, as well as guidelines for screening.

The data sharing efforts are also key work to ensure data sharing practices are a supporting bi-directional care. One of the tools that HCA has offered is a toolkit around confidentiality and data sharing (https://www.hca.wa.gov/assets/billers-and-providers/60-0077-washington-confidentiality-toolkit-providers.pdf).

Currently the MCOs are working on a collaborative Performance Improvement Project centering on ending disparities within racial and ethnic groups for children and youth needing mental health treatment services. The MCOs have partnered with several primary care offices to reach out to children and youth who have been identified as needing follow up care to secure referrals for on-going behavioral health treatment services. This project includes providing care gap reports for identified children/youth, tracking phone call outreach, and referral processes. They are currently collecting data on these pilot projects and will incorporate the information and processes within their quality improvement work moving forward.

c) Efforts to integrate primary care into behavioral health settings

The Washington Integrated Care Assessment work is a significant effort in supporting behavioral health agencies in developing and strengthening clinically integrated models, inclusive of bringing in primary care. The WA-ICA offers a tool specifically tailored for behavioral health agency settings and provides a roadmap along key domains to move the dial towards more integrated care. The tool is structured in a way that embraces organizations at all levels of integration, from beginner level through intermediate to advanced, or more sophisticated levels of integrated care. It is designed as a quality improvement roadmap.

Washington is also embracing the Certified Community Behavioral Health Clinic (CCBHC) model, which focuses on ensuring integrated outpatient services, as well as prevention and crisis stabilization. Currently there are 17 CCBHCs in Washington, with more coming on board. The legislature directed HCA to provide a report at the end of 2024 exploring the development and implementation of a sustainable alternative payment model for comprehensive community services, including CCBHCs. In addition to the analysis work for the report, HCA is moving forward with an implementation plan with a goal that 90% of Washingtonians will be in a county or be within driving distance of a county with a CCBHC. Part of this work will entail working with stakeholders

to determine the level of integration of primary care into these settings.

Finally, a state plan amendment was just submitted for the rehabilitative services section of our state plan that strives to de-silo mental health and substance use disorder services sections, as well as broaden the array of allowable provider types to give providers more flexibility in delivering co-occurring and integrated models of care. Pending CMS approval, the amendment will go into effect January 2024. HCA will then look at a phase 2 state plan amendment to determine further changes to the state plan that would bolster and support more integrated models.

4. Describe how the state provides care coordination, including detail about how care coordination is funded and how care coordination models provided by the state vary based on the seriousness and complexity of individual behavioral health needs. Describe care coordination available to:

a) Adults with serious mental illness

b) Adults with substance use disorders

c) Children and youth with serious emotional disturbances or substance use disorders

Within Washington, care coordination is offered as a benefit for individuals receiving Medicaid through a managed care plan. We currently contract with five MCOs who all provide care coordination to children, youth and adults experiencing serious mental illness, serious emotional disturbances and SUD. Each MCO has created levels of care coordination based on the needs of individuals and level of care coordination need. MCO care coordination funding is included within the per capita rates. Additionally, there are services, such as WISe (Wraparound with Intensive Services) and PACT (Program for Assertive Community Treatment) that contain care coordination as integral components.

5. Describe how the state supports the provision of integrated services and supports for individuals with co-occurring mental and substance use disorders, including screening and assessment for co-occurring disorders and integrated treatment that addresses substance use disorders as well as mental disorders. Please describe how this system differs for youth and adults.

As of January 2020, Washington fully integrated the Medicaid behavioral health and physical health benefit under an integrated managed care structure, allowing the full continuum of physical and behavioral health care to be managed through health plan managed care contracts. These contracts integrate the financing of physical and behavioral health care and include value-based payment to drive innovation and clinical integration at the practice level. The five Managed Care Organizations function as a single payor, accountable for ensuring whole person integrated care, as well as care coordination. As part of the shift to integrated managed care, the Division of Behavioral Health and Recovery moved to the Health Care Authority, to ensure integrated oversight of both behavioral health and physical health services.

In mid-2020, HCA partnered with our Managed Care Organizations and Accountable Communities of Health to identify a new clinical integration assessment tool to better support the advancement of bi-directional physical and behavioral health clinical integration in Washington State. The tool, called the Washington Integrated Care Assessment (WA-ICA), serves as a standard assessment and quality improvement roadmap that can be used by primary care and behavioral health providers. In 2022, this tool was piloted across the state with an initial cohort of providers. HCA is reviewing the results of that initial pilot and is in the process of determining next steps, to include determining the necessary infrastructure and funding resources available to advance this work. Additional information can be found on the website at https://www.hca.wa.gov/about-hca/programs-and-initiatives/advancing-clinical-integration/what-were-working.

Within Washington, care coordination is offered as a benefit for individuals receiving Medicaid through a managed care plan. We currently contract with five MCOs who all provide care coordination to children, youth and adults experiencing serious mental illness, serious emotional disturbances and SUD.

From a data perspective, HCA is supporting the use of the Clinical Data Repository (CDR) as a tool to advance Washington's capabilities to collect, share and use integrated physical and behavioral health information from provider EHR systems. The CDR is a real time database that consolidates data from a variety of clinical sources to present a unified view of a single patient.

Within the child and youth population in Washington state, young children (birth – age 5) have the highest rates of unmet mental health care needs (HCA, 2022). Research suggests that challenges around reimbursement systems and specialty training are key barriers to access (Perigee Fund, 2021).

In SFY22-23, Washington engaged in several efforts to improve access to care for young children and their families, through specific work around developmentally appropriate mental health assessment and diagnosis, including:

• Revised reimbursement policies to adequately fund assessments best practices, including assessments that take multiple sessions and/or take place in home and community settings (i.e., natural environments). An evaluation of the impact of these reimbursement changes on service delivery will be conducted in SFY24-25.
• Free training in the DC:0-5, the developmentally appropriate diagnostic manual for young children's mental health, which is recommended by both CMS and SAMHSA. Training will continue through SFY24-25.
• Additional tools and resources to support the use of the DC:0-5, including a community-informed DC:0-5 crosswalk, and updated administrative code to allow the use of the DC:0-5 in individual service records. Additional tools and resources will be developed through SFY24-25.

Washington's innovations in this area have been featured in several national publications and conferences, but we know there is still more work to do. Our recent report highlighted the positive impacts of these policy changes, but also areas where challenges remain. In SFY24-25, we will conduct Listening Sessions with providers from each region of the state to better understand challenges and needs, which will inform our ongoing work in this area.

Please indicate areas of technical assistance needed related to this section.

None at this time.

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Footnotes:

Environmental Factors and Plan

2. Health Disparities - Required

Narrative Question

In accordance with Advancing Racial Equity and Support for Underserved Communities Through the Federal Government (Executive Order 13985), Advancing Equality for Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex Individuals (Executive Order 14075), the **HHS Action Plan to Reduce Racial and Ethnic Health Disparities**[1], **Healthy People, 2030**[2], **National Stakeholder Strategy for Achieving Health Equity**[3], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and M/SUD outcomes among individuals of all cultures, sexual orientations, gender identities, races, and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (e.g., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the **Behavioral Health Implementation Guide for the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care** (CLAS)[4].

Collecting appropriate data are a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status[5]. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations[6]. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBTQI+ populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide M/SUD services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the populations they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. In addition, LGBTQI+ individuals are at higher risk for suicidality due to discrimination, mistreatment, and stigmatization in society. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is and is not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations.

[1] **https://www.minorityhealth.hhs.gov/assets/pdf/hhs/HHS_Plan_complete.pdf**

[2] **https://health.gov/healthypeople**

[3] **https://www.mih.ohio.gov/Portals/0/Documents/CompleteNSS.pdf**

[4] **https://thinkculturalhealth.hhs.gov/**

[5] **https://aspe.hhs.gov/basic-report/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-and-disability-status**

[6] **https://www.whitehouse.gov/wp-content/uploads/2017/11/Revisions-to-the-Standards-for-the-Classification-of-Federal-Data-on-Race-and-Ethnicity-October30-1997.pdf**

Please respond to the following items:

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, sexual orientation, gender identity, and age?

		Yes	No
	a) Race	◉ Yes	○ No
	b) Ethnicity	◉ Yes	○ No
	c) Gender	◉ Yes	○ No
	d) Sexual orientation	○ Yes	○ No
	e) Gender identity	○ Yes	◉ No
	f) Age	◉ Yes	○ No
2.	Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population?	◉ Yes	○ No
3.	Does the state have a plan to identify, address and monitor linguistic disparities/language barriers?	◉ Yes	○ No
4.	Does the state have a workforce-training plan to build the capacity of M/SUD providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations?	○ Yes	◉ No
5.	If yes, does this plan include the Culturally and Linguistically Appropriate Services (CLAS) Standards?	○ Yes	◉ No
6.	Does the state have a budget item allocated to identifying and remediating disparities in M/SUD care?	○ Yes	◉ No

7. Does the state have any activities related to this section that you would like to highlight?

Health Care Authority
The Health Care Authority (HCA) has always done equity work because Medicaid is a tool to support underserved populations. However, as of three years ago there was no standardized and unified process, and no dedicated FTE for health equity. In 2021, HCA established the Health Equity Director position as well as including liaison responsibilities to at least one staff person in each division to connect each division's health equity work across the agency.

By the end of 2021, all of HCA employee's job description included the statement HCA employees will apply an equity lens to their work, which may include but is not limited to all analyses of core business and processes. Using an equity lens is critical in our programs or projects and especially when doing legislative reviews. Using that health equity lens helps to ensure that any disparities in BH services are addressed and removed.

Alongside that, a health equity toolkit was created to help staff understand and apply an equity lens to design and evaluate all of our policies, programs and services. This includes identifying and addressing disparities during the legislative session, where we give input on hundreds of bills. Adding this equity lens has shown a difference in how we evaluate and support bills, services and programs.

In 2022, Governor Inslee issued the Pro Equity Anti Racism executive order, aka PEAR, requiring all state agencies to have a plan to become pro-equity and anti-racist. One of our accomplishments was the establishment of the PEAR community advisory team - CAT. This team is comprised of community members, specifically those who have historically be underserved or underrepresented, who advise our internal PEAR team.

The PEAR and PEAR CAT teams identified 4 key areas known as workstreams that HCA has committed to in 2023. They are:

• Community engagement – which is not to be mistaken for stakeholdering. HCA has launched the first community engagement mini guide. This guide provides insight on how to engage communities in all the various work that you do.
• Data equity strategy – HCA believes in data to back the work being done, and for that data to provide the truth on the services we provide, who is not able to receive services, and identify existing barriers that keep them from reaching out for services in their communities.
• Leadership & operation strategy to enhance health equity – HCA wants to ensure there is clear buy-ins from leadership and is reflected through our daily operations.
• Workforce equity - This is not only focusing on our internal HCA workforce, but also looking at Washington State's health care workforce as a whole. We are exploring ways to create a health workforce to serve all of WA, especially for rural and underserved populations.

We also focus on tribal implications to ensure that there is appropriate government to government collaboration.

Division of Behavioral Health and Recovery Services
Diversity, equity, inclusion, belonging (DEIB), and social justice are not just words to the Division of Behavioral Health and Recovery (DBHR). We are striving to become more intentional about our efforts to embrace the principles of DEIB, health equity, and social justice in the behavioral health field while continuing to break down systemic 'isms that continue to create barriers

around treating individuals with behavioral health challenges.

DBHR approached the need for better awareness about cultural awareness, racism, unconscious bias, health equity, inclusion and belonging by launching the DBHR DEIB Advisory Team. This team is attended by staff from all levels and from varying functions. This Advisory team has the responsibility to create a framework of how DBHR will operationalize and embed DEIB core business functions to include recruitment/promotion/retention, strategic planning around DEIB, performance management, and position descriptions. They are also working to building cultural awareness among division staff by instituting a "DEIB 10" moment at monthly all-staff meetings.

DBHR continues to do positive work to address and combat stigma around mental health and substance use disorder (SUD). For example, Recovery Syn-ERG is an outlet for HCA staff to support others who have or still going through their recovery journey; the Prevention Health Equity workgroup has created an infrastructure that stands by, implements, and monitors for CLAS standards; and ensuring DEIB and Health Equity workshops are a part of any HCA/DBHR supported conferences.

Please indicate areas of technical assistance needed related to this section

We will reach out to SAMHSA for TA when needed.

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Footnotes:

Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

While there are different ways to define value-based purchasing, its purpose is to identify services, payment arrangements, incentives, and players that can be included in directed strategies using purchasing practices that are aimed at improving the value of health care services. In short, health care value is a function of both cost and quality:

Health Care Value = Quality ÷ Cost, (**V = Q ÷ C**)

SAMHSA anticipates that the movement toward value-based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of M/SUD systems and services. The **National Center of Excellence for Integrated Health Solutions**[1] offers technical assistance and resources on value-based purchasing models including capitation, shared-savings, bundled payments, pay for performance, and incentivizing outcomes.

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including M/SUD services. Over the past several years, SAMHSA has collaborated with CMS, HRSA, SMAs, state M/SUD authorities, legislators, and others regarding the evidence for the efficacy and value of various mental and substance use prevention, SUD treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states' use of the block grants for this purpose. The NQF and the IOM/NASEM recommend that evidence play a critical role in designing health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. SAMHSA's Evidence Based Practices Resource Center (EBPRC) assesses the research evaluating an intervention's impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. SAMHSA's EBPRC provides the information & tools needed to incorporate evidence-based practices into communities or clinical settings.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions used with individuals with mental illness and substance use disorders, including youth and adults with substance use disorders, adults with SMI, and children and youth with SED. The recommendations build on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General[2], The New Freedom Commission on Mental Health[3], the IOM, NQF, and the **Interdepartmental Serious Mental Illness Coordinating Committee** (ISMICC)[4].

One activity of the EBPRC[5] was a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in “Psychiatry Online.”[6] SAMHSA and other HHS federal partners, including the Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the M/SUD field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many innovative and promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, evidence is collected to determine their efficacy and develop a more detailed understanding of for who and in what circumstances they are most effective.

SAMHSA's Treatment Improvement Protocol Series **(TIPS)**[7] are best practice guidelines for the SUD treatment. SAMHSA draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation **(KIT)**[8] was developed to help move the latest information available on effective M/SUD practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement M/SUD practices that work. Each KIT covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice

demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, for educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is interested with what additional information is needed by SMHAs and SSAs to support their and other purchasers' decisions regarding value-based purchase of M/SUD services.

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[1] **https://www.thenationalcouncil.org/program/center-of-excellence/**

[2] United States Public Health Service Office of the Surgeon General (1999). *Mental Health: A Report of the Surgeon General*. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

[3] The President's New Freedom Commission on Mental Health (July 2003). *Achieving the Promise: Transforming Mental Health Care in America*. Rockville, MD: Department of Health and Human Services, Substance use disorder and Mental Health Services Administration.

[4] National Quality Forum (2007). *National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices*. Washington, DC: National Quality Forum.

[5] **https://www.samhsa.gov/ebp-resource-center/about**

[6] **http://psychiatryonline.org/**

[7] **http://store.samhsa.gov**

[8] **https://store.samhsa.gov/?f%5B0%5D=series%3A5558**

Please respond to the following items:

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions? ◯ Yes ◯ No

2. Which value based purchasing strategies do you use in your state (check all that apply):

- **a)** ☐ Leadership support, including investment of human and financial resources.
- **b)** ☐ Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
- **c)** ☐ Use of financial and non-financial incentives for providers or consumers.
- **d)** ☐ Provider involvement in planning value-based purchasing.
- **e)** ☐ Use of accurate and reliable measures of quality in payment arrangements.
- **f)** ☐ Quality measures focused on consumer outcomes rather than care processes.
- **g)** ☐ Involvement in CMS or commercial insurance value-based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P)).
- **h)** ☐ The state has an evaluation plan to assess the impact of its purchasing decisions.

3. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

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Footnotes:

Environmental Factors and Plan

4. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) - 10 percent set aside - Required MHBG

Narrative Question

Much of the mental health treatment and recovery service efforts are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among consumers and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention* is critical to treating mental illness before it can cause tragic results like serious impairment, unemployment, homelessness, poverty, and suicide. The duration of untreated mental illness, defined as the time interval between the onset of a mental disorder and when an individual gets into treatment, has been a predictor of outcomes across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be viewed as a negative prognostic factor for those who are diagnosed with mental illness. Earlier treatment and interventions not only reduce acute symptoms, but may also improve long-term prognosis.

SAMHSA's working definition of an Early Serious Mental Illness is "An early serious mental illness or ESMI is a condition that affects an individual regardless of their age and that is a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-5 (APA, 2013). For a significant portion of the time since the onset of the disturbance, the individual has not achieved or is at risk for not achieving the expected level of interpersonal, academic or occupational functioning. This definition is not intended to include conditions that are attributable to the physiologic effects of a substance use disorder, are attributable to an intellectual/developmental disorder or are attributable to another medical condition. The term ESMI is intended for the initial period of onset."

States may implement models that have demonstrated efficacy, including the range of services and principles identified by National Institute of Mental Health (NIMH) via its Recovery After an Initial Schizophrenia Episode **(RAISE)** initiative. Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, states should move their system to address the needs of individuals with a first episode of psychosis (FEP). RAISE was a set of NIMH sponsored studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP. The NIMH RAISE studies, as well as similar early intervention programs tested worldwide, consist of multiple evidence-based treatment components used in tandem as part of a Coordinated Specialty Care (CSC) model, and have been shown to improve symptoms, reduce relapse, and lead to better outcomes.

State shall expend not less than 10 percent of the MHBG amount the State receives for carrying out this section for each fiscal year to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset. In lieu of expending 10 percent of the amount the State receives under this section for a fiscal year as required a state may elect to expend not less than 20 percent of such amount by the end of such succeeding fiscal year.

* MHBG funds cannot be used for primary prevention activities. States cannot use MHBG funds for prodromal symptoms (specific group of symptoms that may precede the onset and diagnosis of a mental illness) and/or those who are not diagnosed with a SMI.

Please respond to the following items:

1. Please name the model(s) that the state implemented including the number of programs for each model for those with ESMI using MHBG funds.

Model(s)/EBP(s) for ESMI/FEP	Number of programs
New Journeys-coordinated specialty care model based on Navigate (EBP).	15

2. Please provide the total budget/planned expenditure for ESMI/FEP for FY 24 and FY 25 (only include MHBG funds).

FY2024	FY2025
3891004	3891004

3. Please describe the status of billing Medicaid or other insurances for ESMI/FEP services? How are components of the model currently being billed? Please explain.

New Journeys has used a combination of federal block grant funds, state and local funds, and Medicaid and commercial insurance billing to finance teams since the first pilot site in 2015. Several New Journeys services are difficult to bill public or commercial insurance through traditional fee-for-service methods, including care coordination, community outreach, and specialty screening. Commercial insurance often only covers psychotherapy, medication and medication management, and family therapy, and some providers do not have the infrastructure to seek commercial insurance payments. Currently, these gaps in reimbursement are covered by either state general funds or federal block grant funds.

In July 2022, Washington implemented a team-based rate for Medicaid. Billing through the Medicaid team-based rate is projected to result in reimbursements of $415,584 per team annually, covering an estimated 76% of New Journeys team costs. Washington's implementation of a Medicaid team-based rate will greatly expand the funding available to the New Journeys network. Since launching the team-based rate, New Journeys has been able to transition 7 teams from federal block grant funds.

Additional funds to account for non-Medicaid activities are paid for with state funds through MCO Wrap Contracts. The non-Medicaid components of the model are funded, over and above, the team-based rate to pay for 36% of the team's time to provide non-Medicaid activities required for fidelity. Two slots per team for underinsured participants are funded through BH-ASO contracts. Training, quality improvement and fidelity activities, as well as start-up and case building of new teams are supported through federal block grant funds.

Washington Health Care Authority is currently partnering with Mercer actuarial group to develop an encounter rate for New Journeys teams. The updated financing will help expand Medicaid funding, covering team costs more fully, providing more options and flexibility in billing to support rural and cultural CSC adaptations.

4. Please provide a description of the programs that the state funds to implement evidence-based practices for those with ESMI/FEP.

New Journeys is a coordinated specialty are model based on Navigate. The model offers an array of Medicaid and Non-Medicaid funded recovery support interventions for screening and early identification of psychosis. The service array is already included in the State plan and is provided by a multidisciplinary team that offers a coordinated and specialized approach that targets an individual's unique needs and provides more intensive supports compared to regular outpatient treatment. Each New Journeys team is structured using 4.25 FTE's. Each team serves no more than 30 individuals at a given time.

The New Journeys team members include:

• Program Director/Family Education Provider (1.0 FTE)
• Psychiatric Care Provider (0.25
• FTE)
• Individual Resiliency Training (IRT) Clinician (1.0 FTE)
• Supported Employment and Education (SEE) Specialist (1.0 FTE)
• Peer Support Specialist (0.5 FTE)
• Case Manager and/or Registered Nurse Care Manager (0.5 FTE)

Teams may choose to substitute a nurse care manager (~0.2 FTE) for all or part of the case manager FTE count.

These services are intended to be low barrier and generally available in home, school, community, and clinic settings. This treatment also includes a public education and outreach function that is intended to hasten the identification and rapid referral of youth and young adults experiencing symptoms.

5. Does the state monitor fidelity of the chosen EBP(s)?

(●) Yes ( ) No

6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI/FEP?

(●) Yes ( ) No

7. Explain how programs increase access to essential services and improve client outcomes for those with an ESMI/FEP?

Those experiencing ESMI/FEP often present with special issues related to engagement. Use of outpatient mental health services is the

lowest in young adulthood. Data suggests that 46% of those who met criteria for SMI do not receive treatment (IOM, 2015, CMHS, 2011; National Survey of Drug Use and Health, 2018). Research indicates youth and young adults benefit from support to navigate transitions from hospitals, jails, crisis situations and independent living. New Journeys often provides these supports during a vital time in someone's life.

New Journeys provides outreach and intervention for transition-aged youth (>15), young adults and their families when first diagnosed with psychosis. Members of the New Journeys treatment team will travel to the home, school, or elsewhere in the community to provide assessment, screening, and therapy for people affected by first episode psychosis. New Journeys also utilizes family and peer support partners to assist with engagement.

The first 6 months of the New Journeys model is focused on engagement. The overall goal is early intervention (decreasing the DUP) and minimizing more restrictive interventions such as jail, hospitalizations, or intervening to minimize consequences of untreated symptoms such as eviction, being taken advantage of by others, misdiagnosis, substance use, self-harm. dropping out of school or losing employment.)

8. Please describe the planned activities for FY 2024 and FY 2025 for your state's ESMI/FEP programs.

• Continued expansion of New Journeys teams based on incidence and population needs.
• Continued development of rural and AI/AN pilot adaptations to address needs of those at risk of being underserved.
• Launch the New Journeys encounter rate on July 1, 2025.
• Training and support for the ESMI/FEP behavioral health workforce
• Pilot work to expand diagnostic criteria to include affective psychosis in 2025.

9. Please list the diagnostic categories identified for your state's ESMI/FEP programs.

Primary diagnosis of one of the following:
• Schizophrenia
• Schizoaffective disorder
• Schizophreniform disorder
• Brief Psychotic disorder
• Delusional disorder
• Other specified Psychotic disorder

10. What is the estimated incidence of individuals with a first episode psychosis in the state?

In 2021 Research Data and Analysis (RDA), estimated that more than 2,000 youth and young adults in Washington experienced a first episode. This is a low estimate as it only accounts for individuals receiving Medicaid or Medicare. Thinking about these numbers differently, would equate to 235 individuals per 100,000 Medicaid Enrollees.

These numbers are based on the most recent census data available and population-based incidence rates and validated by retrospective analysis of administrative data by the Washington State Department of Social and Health Services Research and Data Analysis Division (RDA).

11. What is the state's plan to outreach and engage those with a first episode psychosis who need support from the public mental health system?

A primary goal of the state's initiative to support early identification and treatment of first episode psychosis and psychosis risk states is to accurately identify youth and young adults earlier in the course of psychotic illness. Doing so unequivocally supports engagement in coordinated specialty care, reduces the Duration of Untreated Psychosis, and can prevent inpatient hospitalizations. New Journeys includes a local public education and outreach function that is intended to hasten the identification and rapid referral of youth and young adults experiencing symptoms.

The Central Assessment of Psychosis Service (CAPS) Expansion projects seeks to create a statewide public health campaign to raise awareness of psychosis risk states and development toward professional tele-consultation concerning new-onset psychosis and psychosis risk.

CAPS supports crisis intervention work by providing a diagnostic and referral service during the workforce shortage where there is currently pressure on the front door of the system of care and lack of staff to perform this function. This service would support front door access decreasing the need for crisis interventions. A stage-wise expansion, executed in collaboration with Health Care Authority; New Journeys Network; Washington State Center of Excellence for Early Psychosis; New Journeys evaluation partner, Washington State University; and University of Washington Medicine.

The New Journeys Virtual Gathering is a two-day virtual event focused on Early Identification and Treatment of First Episode Psychosis and marketed across networks throughout Washington State. The event is organized in collaboration Health Care Authority and representatives of the New Journeys Network of clinicians and trainers from all over the state. The event aimed to provide attendees with education, resources, best practices, and hopeful outlooks for supporting and identifying individuals experiencing first episode psychosis.

Please indicate areas of technical assistance needed related to this section.

Public education and anti-stigma for FEP
Autism and FEP
TA for the intersection of financing with CSC and CCBHC's

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Footnotes:

Environmental Factors and Plan

5. Person Centered Planning (PCP) - Required for MHBG

Narrative Question

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers where appropriate in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning is a process through which individuals develop their plan of service. The PCP may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP team may include family members, legal guardians, friends, caregivers and others that the person or his/her representative wishes to include. The PCP should involve the person receiving services and supports to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person's strengths, goals, preferences, needs and desired outcome. The role of state and agency workers (for example, options counselors, support brokers, social workers, peer support workers, and others) in the PCP process is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs and provide support during planning. The person's goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, education, family relationships, and treatments are part of a written plan that is consistent with the person's needs and desires.

In addition to adopting PCP at the service level, for PCP to be fully implemented it is important for states to develop systems which incorporate the concepts throughout all levels of the mental health network. Resources for assessing and developing PCP systems can be found at the National Center on Advancing Person-Centered Practices and Systems **https://ncapps.acl.gov/home.html** with a systems assessment at **https://ncapps.acl.gov/docs/NCAPPS_SelfAssessment_201030.pdf**

1. Does your state have policies related to person centered planning? ◉ Yes ○ No

2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.

N/A

3. Describe how the state engages consumers and their caregivers in making health care decisions, and enhance communication.

The Program of Assertive Community Treatment (PACT), the First Episode Psychosis New Journeys program, and the Wraparound with Intensive Services (WISe) models define a specific process for treatment planning that are very inclusive of the individuals and their family or others identified by the individual as part of their treatment team. These are person-centered explorations of strengths and challenges across multiple life domains. Fidelity monitoring specifically looks for inclusion of natural supports and PACT fidelity monitoring ensures that all members of PACT teams receive person centered planning training.

In addition to those individuals receiving PACT, New Journeys, and WISe services, all individuals receiving outpatient mental health services are engaged in the development of an individualized service plan. Washington Administrative Code WAC 246-341-0620directs outpatient mental health providers to develop individualized treatment plans that are "consumer-driven, strengths-based, and meet the individual's unique mental health needs". Further, these plans must identify services mutually agreed upon by the individual and provider. Washington State promotes the use of Mental Health Advance Directives, a method by which an individual can communicate their decisions about mental health treatment in advance of times when they are incapacitated.

4. Describe the person-centered planning process in your state.

Individuals receiving their mental health treatment under the authorization of the managed care benefits participate in a collaborative treatment planning process. This process draws upon the needs identified across life domains during the assessment, as well as their strengths and challenges. Treatment is individualized and determined in partnership with the individual as well as those natural supports that the individual chooses to include in their care planning. Treatment plans often include client quotations that document their goals. These treatment plans are living documents that are revisited over the course of treatment and adapted based up on client needs and preferences. Programs such as WISe, Navigate, and PACT stress an even greater emphasis on person centered planning, as described above.

5. What methods does the SMHA use to encourage people who use the public mental health system to develop Psychiatric Advance Directives (for example, through resources such as SAMHSA's **A Practical Guide to Psychiatric Advance Directives**)?"

Chapter 71.32 of the revised code of WA requires behavioral health providers to ensure anyone accessing care and/or their caretakers be informed of advanced directives and supported in completing them if requested. At https://www.hca.wa.gov/free-or-low-cost-health-care/i-need-behavioral-health-support/mental-health-advance-directives HCA provides policy education and support to behavioral health providers toward this goal.

Please indicate areas of technical assistance needed related to this section.

None at this time.

Footnotes:

Environmental Factors and Plan

6. Program Integrity - Required

Narrative Question

SAMHSA has a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds.

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for M/SUD services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x–5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x-55(g), SAMHSA periodically conducts site visits to MHBG and SUPTRS BG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SUPTRS BG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: **http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf**. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SUPTRS BG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SUPTRS BG funds are allocated to support evidence-based, culturally competent programs, substance use primary prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for M/SUD services funded by the MHBG and SUPTRS BG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered M/SUD benefits; (3) ensuring that consumers of M/SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of M/SUD benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please respond to the following:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers? ◉ Yes ○ No

2. Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards? ◉ Yes ○ No

3. Does the state have any activities related to this section that you would like to highlight?

DBHR program managers work with their contractors to review claims, identify overpayments, and educate providers and others on block grant program integrity issues.

DBHR also provides support and assistance to the Behavioral Health Administrative Service Organizations (BH-ASOs) and Tribes in their efforts to combat fraud and abuse as well as to promote best practices in an effort to raise awareness of fraud, waste, and abuse.

Contract requirements are passed down to subcontractors, which are reviewed and discussed prior to the subcontracts being sent out to providers. Contract managers conduct reviews at least once per year or once per biennium. Additional reviews may be done if there are challenges with providers or providers request technical assistance. In addition to contract monitoring, the Behavioral Health Administration, Division of Budget and Finance conducts an annual review of the BHOs' financial information. Part of the fiscal monitoring is to ensure that block grant funds are being used appropriately. If deficiencies are found, a corrective action plan is initiated and reviews occur more frequently.

On a monthly basis:

• Budget and Finance Division in conjunction with DBHR leadership conducts monthly reviews of the block grant budgets.
• Claim and payment adjustments are done as needed to ensure block grant expenditures are being properly recorded for allowable block grant services.
• Expenditure reports are reviewed monthly, and invoices are reviewed and approved by the contract manager prior to the payment being issued.
• Client level encounter, utilization, and performance analysis are completed as part of the invoice approval process and contract/fiscal monitoring process.

Please indicate areas of technical assistance needed related to this section

None at this time.

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7. Tribes - Requested

Narrative Question

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the **2009 Memorandum on Tribal Consultation**[56] to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that approximately 70 percent of American Indians and Alaska Natives do not live on tribal lands. The SMHAs, SSAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the states.

States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

[56] **https://www.energy.gov/sites/prod/files/Presidential%20Memorandum%20Tribal%20Consultation%20%282009%29.pdf**

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?

The State of Washington follows the Revised Code of Washington RCW 43.376 pertaining to the State's government-to-government relationship with Indian Tribes. All State agencies shall make reasonable efforts to collaborate with Indian tribes in the development of polices, agreements, and program implementation that directly affect Indian Tribe and develop a formal consultation policy. https://app.leg.wa.gov/RCW/default.aspx?cite=43.376.020. The WA State Health Care Authority is one of many state agencies that conducts several consultations each year following their HCA Consultation Policy. https://www.hca.wa.gov/assets/program/tribal_consultation_policy.pdf. Below is a listing of the consultations that have been conducted by the HCA over the past two years.

- Health Homes Roundtable/Consultations, Jan/Feb 2022
- Managed Care Organization Practices Consultation, Apr 2022
- Primary Case Management Entity (PCCMe), May 2022
- Medicaid Transformation Program Renewal/Native Hub, Jun 2022
- 988 Technical and Operation Plan, Sept 2022
- Opioid Abatement Settlement, Oct 2022
- 988 Comprehensive Assessment, Dec 2022
- Community Health Woker Grant Listening Session, Feb 2023
- Community Health Aide Program State Plan Amendment (SPA), Mar 2023
- 13d Rehabilitative Services SPA, Apr 2023
- Block Grant Listening Session, May 2023
- Opioid Settlement Listening Session, June 2023
- Block Grant Tribal Roundtable, July 2023

• Block Grant Tribal Roundtable 2, July 2023
• Block Grant Tribal Consultation, August 2023

The Health Care Authority follows a communication and consultation policy that government to government relationships and protocols for Tribes, Urban Indian health programs, and boarder tribes of Washington State.

2. What specific concerns were raised during the consultation session(s) noted above?

During the several consultations over the past couple of years, several main concerns have been raised by Tribal leaders and Tribal representatives regarding behavioral health services. Below is a summary of those concerns.
• This continues to be a significant concern for Tribes in which – Tribes have identified several gaps in access to services specifically for individuals that are not in managed care. Tribal representatives have identified access to care in accessing high acute evaluation and treatment services, detox services, secure withdrawal management, and crisis services. Some of these access to care concerns is said to be related to the low rates for individuals that are not in managed care when over 60% of the AI/AN population is not assigned to a managed care entity. This percentage is due to the risk of unintended negative impacts for AI/AN in receiving culturally appropriate care through Tribal services when opted into managed care. During legislative session the HCA submitted a request for funding to bring FFS up to parity with managed care rates which was supported by the Governor and passed through the legislature.
• Since 2020 the Tribes and Urban Indian Health Programs, raised significant concerns related to managed care practices in working with IHCPs and the challenges in receiving payments for Medicaid services from Managed Care Organizations (MCO)s.
• When discussions of funding and contracting are discussed, Tribes continue to voice concerns regarding the administrative burden of managing federal pass-through dollars.
• Tribes have raised concerns about any requirements and language that only considers evidence-based practices as treatment modalities and does not consider that EBPs may not have enough evidence with under-represented communities and the lack of data for culturally based programs in being defined as an EBP. This language can at times place an unintended consequence to not consider culturally appropriate care and can also place stigma on culture-based modalities such as traditional healing practices.
• Tribes have also raised any issues of not having direct Tribal set asides for programs that are implemented by the State by being passed down to providers.

Tribal communities were impacted greatly by the COVID pandemic. Tribes were very proactive in addressing the pandemic for the health and safety of their people, closing non-emergency operations and limiting access to Tribal lands by early March 2020 prior to the Governor's Stay at Home order. Due to this change, Tribes led efforts to identify innovative mechanisms to connect with their clients in treatment and within social services environments; however, restrictions and limitations on community events or gatherings were very difficult for tribal communities. Ceremony and traditional community gatherings are part of culture that has healed and supported tribal communities throughout the years. For example, the annual historical Canoe Journey, has been canceled for the past two years. Tribal communities have made difficult decisions to require changes for conducting traditional funeral ceremonies. In many communities, recovery support services were no longer held in person or were not scheduled due the need to social distance to keep people safe. As the pandemic continued, Tribal communities focused heavily on planning and preparing for the worst. When vaccinations became available, Tribes prioritized vaccine administration and education for elders, adults, employees, and community members, extending into vaccination of their surrounding communities.

?One key issue that has been raised during this time is the significant increase in overdose rates amongst AI/AN individuals in WA State. In an early statistic, the overdose rates for AI/AN population had increased to over 150% during the first 6 months of the pandemic. The American Indian/Alaska Native Opioid Response workgroup provided a startling presentation of youth and adult opioid use and overdose rates over the course of the pandemic.

In response, Tribal communities, in partnership with Tribal lead organizations and federal and state partners, continue to work to address the behavioral health concerns of their Tribal members and community members while continuing to address this pandemic and to find innovative ways to reach their people for behavioral health needs. This includes having drive-thru wellness events, holding smaller gatherings, holding socially or physically distanced cultural activities, finding support for youth involved in online learning, improving telehealth resources, and improved internet access for their community members.

3. Does the state have any activities related to this section that you would like to highlight?

The Health Care Authority has several activities to improve access to behavioral health services for AI/AN individual and to engage in government-to-government partnership with Tribes.

• HCA Office of Tribal Affairs in partnership with the State legislature and the American Indian Health Commission, Northwest Portland Area Indian Health Board, and DOH, established the Tribal 988 Subcommittee focused on implementation of 988 and other crisis activities outlined in legislative bills, 1477 and 1134.
• HCA has worked to support the implementation of the Native and Strong Lifeline, Tribal 988 crisis line for Native individuals in WA. This includes support for direction of implementation alongside Tribal 988 Subcommittee and the Department of Health. HCA provided funding to launch a media campaign for both the Indian BH Hub and the NSL. HCA is supporting expansion of the Indian BH Hub for regional hub navigators.
• HCA continues to support managed care rapid response and D
• The HCA has worked extensively to ensure that MCOs pay Tribes at the encounter rate in a timely fashion. The HCA has implemented weekly rapid response calls, addressed issues directly with each MCO, extensively review of successful MCO

payments to Tribes, and provided extensive TA and guidance to both IHCPs and MCOs.
• The HCA has several set-aside projects now being implemented through the HCA/Indian Nation Agreements with 28 of the 29 Tribes in Washington and also working to provide funding to urban Indian Health Organizations and other Tribal organizations.
• The HCA continues to support the work of the Tribal Centric Behavioral Health Advisory Board that focuses on crisis system improvements for AI/AN individuals and Tribal communities.
• The HCA continues to support the AI/AN Opioid Response Workgroup to address the Opioid Crisis and increase in opioid overdoses amongst AI/AN individuals following the pandemic and stay at home orders. And is now in year 5 of the implementation of the Tribal Opioid Solutions Campaign. This year, HCA partnered with the Department of Health with the same contractor working on the Opioid Solutions Campaign to develop the Tribal Suicide Prevention Campaign. These new campaign assets were launches at the same time and can be found of the following websites. The media firm working on these campaigns will also be providing technical assistance to Tribe and urban Indian organizations to localize these materials as well as launching a statewide media buy. https://watribalopioidsolutions.com/ , https://watribalopioidsolutions.com/suicide-prevention-toolkit
• The HCA has provided dedicated funds to offer free training to non-Tribal agencies and providers in working with AI/AN and navigation of the Indian Behavioral Health System. This included training to providers who support forensic behavioral health services, designated crisis responders, and HCA staff that oversee statewide behavioral health programs.
• The HCA successfully developed a State Plan Amendment to increase the rates for Tribal Residential SUD providers to $913 dollars as a cost-based rate. This SPA was approved by CMS paving the way for other upcoming Tribal Residential SUD providers to develop a cost-based rate that considerers the implementation of culturally and wrap around recovery support services in their residential SUD treatment programs.

Please indicate areas of technical assistance needed related to this section.

None at this time.

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Footnotes:

Environmental Factors and Plan

8. Primary Prevention - Required SUPTRS BG

Narrative Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***Problem Identification and Referral*** that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. ***Community-based Processes*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Assessment

1. Does your state have an active State Epidemiological and Outcomes Workgroup(SEOW)? ◉ Yes ○ No

2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply) ◉ Yes ○ No

- **a)** ☑ Data on consequences of substance-using behaviors
- **b)** ☑ Substance-using behaviors
- **c)** ☑ Intervening variables (including risk and protective factors)
- **d)** ☑ Other (please list)

Local contributing factors.

3. Does your state collect needs assesment data that include analysis of primary prevention needs for the following population groups? (check all that apply)

- **a)** ☑ Children (under age 12)
- **b)** ☑ Youth (ages 12-17)
- **c)** ☑ Young adults/college age (ages 18-26)
- **d)** ☑ Adults (ages 27-54)
- **e)** ☐ Older adults (age 55 and above)
- **f)** ☑ Cultural/ethnic minorities
- **g)** ☑ Sexual/gender minorities
- **h)** ☑ Rural communities
- **i)** ☑ Others (please list)

Gender and sexual orientation of youth, Disability status of youth, Housing insecurity status of youth

4. Does your state use data from the following sources in its Primary prevention needs assesment? (check all that apply)

a) ☑ Archival indicators (Please list)

For its primary prevention needs assessment, Washington uses the following sources:
• the National Survey on Drug Use and Health,
• Behavioral Risk Factor Surveillance System,
• Youth Risk Behavior Surveillance System,
• Pregnancy Risk Assessment Monitoring System, and
• Monitoring the Future.

The following indicators are used:
a. WA Department of Health, Center for Health Statistics, Death Certificate Data :
i.
ii.
iii. Alcohol related deaths;
iv. Other drug related deaths;
v. Opioid overdose deaths
vi. Suicide Death Rates
b. Uniform Crime Reporting:
i. Alcohol related arrests
ii. Drug related arrests
c. Office of Superintendent of Public Instruction:
i. High School On-Time / Extended Graduation Rates
d. Comprehensive Hospital Abstract Reporting System (CHARS):
i. Alcohol-Injury Related Hospitalizations
ii. Any Non-Fatal Drug Overdose Hospitalizations
iii. Any Non-Fatal Opioid Overdose Hospitalizations
iv. Intentional Self-Harm Hospitalizations
e. WA Department of Transportation and WA State Highway Safety Commission
i. Fatalities and Serious Injury from Crashes: Alcohol-Related Traffic Injuries and Alcohol-Related Traffic Fatalities.
ii. Young Drivers in Fatal Crashes Positive for Delta-9 THC
f. Washington Healthy Youth Survey:
i. Underage Drinking (10th Grade);
ii. Marijuana Misuse/Abuse (10th Grade);
iii. Prescription Misuse/Abuse (10th Grade);
iv. Pain Killer User (10th Grade)
v. Tobacco Misuse/Abuse (10th Grade);
vi. E-Cigarette/Vapor Products Misuse/Abuse (10th Grade);
vii. Polysubstance Misuse/Abuse (10th Grade);
viii. Sad/Hopeless in Past 12 Months (10th Grade);
ix. Suicide Ideation (10th Grade);
x. Suicide Plan (10th Grade);
xi. Suicide Attempt (10th Grade);
xii. Bullied/Harassed/Intimidated (10th Grade);
xiii. Source of Alcohol, Pain Killers Used to Get High; Marijuana; Vapor Products (10th Grade);
xiv. Perception of Availability of Alcohol, Marijuana, Cigarettes; Opioids (10th Grade);
xv. Risk Perception of Alcohol, Marijuana (10th Grade); and
xvi. Knowledge of Laws, Perception of Enforcement – Alcohol, Marijuana (10th Grade),
g. Washington Young Adult Health Survey:
i. Young Adult (18-25) Marijuana Misuse/Abuse;
ii. Opioid Misuse/Abuse;
iii. Alcohol Use; and
iv. Source of Marijuana.
h. Pregnancy Risk Assessment Monitoring System (PRAMS):
i. Pregnant Women Report Alcohol Use Any Time During Pregnancy
ii. Washington State Liquor and Cannabis Control Board:
i. Count of State Liquor Licenses;
ii. Count of State Marijuana Store Licenses and Processor Licenses

b) ☑ National survey on Drug Use and Health (NSDUH)

c) ☑ Behavioral Risk Factor Surveillance System (BRFSS)

d) ☑ Youth Risk Behavioral Surveillance System (YRBS)

e) ☑ Monitoring the Future

f) ☐ Communities that Care

g) ☑ State - developed survey instrument

h) ☑ Others (please list)

Washington additionally uses two state-developed survey instruments: the Healthy Youth Survey and the Young Adult Health Survey.

5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SUPTRS BG primary prevention funds? ◉ Yes ○ No

a) If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based?

Programs, policies, and practices are determined to be evidence-based if they have been tested and shown favorable effects, plus no harmful effects, in one or more evaluation studies including at least one rigorous randomized controlled trial or two rigorous quasi-experimental evaluation studies. This is determined through a review of evidence-based program registry ratings and/or a review of program evaluation literature by DBHR Prevention/Promotion staff with the assistance of university partners which is brought to the Evidence-Based Workgroup for consideration.

b) If no, (please explain) how SUPTRS BG funds are allocated:

6. Does your state integrate the National CLAS standards into the assessment step? ◉ Yes ○ No

a) If yes, please explain in the box below.

The DBHR Prevention Section utilizes CLAS standards into our assessment phase for Community Prevention Wellness Initiative (CPWI) community providers, including but not limited to:
• Coalition Progress Questionnaire which ensures coalitions are assessing how to improve access, retention, and relevance of prevention services to priority populations being served/not being reached by the grant.
• Coalition Assessment Tool which assesses the Coalition’s ability to reach and serve populations of focus and includes a section that assesses the Coalition’s perspective of how cultural competence/health equity are achieved through program delivery.
• The Healthy Youth Survey, which is used as the basis for the needs assessment of each coalition’s strategic plan, assesses the SUD and behavioral health needs of students in each school being served by the grant. The HYS breaks down demographics (race, ethnicity, gender, sexual orientation status, etc.) per the CLAS standards principles, to ensure Coalitions are addressing health disparities in their planning and implementation.

b) If no, please explain in the box below.

7. Does your state integrate sustainability into the assessment step? ◉ Yes ○ No

a) If yes, please explain in the box below.

Sustainability is integrated into the assessment step in a variety of ways, including:
• While Coalitions are completing their Resources Assessment, they consider what programs, policies, strategies, and initiatives exist within the local community to begin with, identifying where there may need to be support from the coalition or school to enhance or maintain prevention services.
• Building partnerships between the Coalitions and the school service areas so that building-level Healthy Youth Survey results can be easily shared and discussed in a collaborative way to support the coalition with strategic planning.
• Coalitions and Educational Services Districts building buy-in from stakeholders and partners in the schools in their service area to ensure continuing participation in the Healthy Youth Survey, as well as getting other eligible schools in those districts/regions to participate in the Healthy Youth Survey. This ensures ongoing eligibility for the BG funding and ability to expand the BG into new service areas if they participate in the Healthy Youth Survey, as it is the mechanism for assessment and evaluation of SUD prevention services.

b) If no, please explain in the box below.

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***Problem Identification and Referral*** that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. ***Community-based Processes*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Capacity Planning

1. Does your state have a statewide licensing or certification program for the substance use primary prevention workforce? (●) Yes ( ) No

a) If yes, please describe.

Yes. Through the Prevention Specialist Certification Board of Washington, the state provides a Certified Prevention Professional (CPP) credential. DBHR supports individuals in obtaining their CPP providing sessions of the Washington Substance Abuse Prevention Skills Training (SAPST) via contract with the Prevention Certification Board. Starting in 2015, DBHR contractually required credentialing of community coalition coordinators.

2. Does your state have a formal mechanism to provide training and technical assistance to the substance use primary prevention workforce? (●) Yes ( ) No

a) If yes, please describe mechanism used.

Yes. DBHR provides training and technical assistance for communities and prevention providers as they implement prevention services. The training plan covers the entire calendar year and includes the following components which provide a number of recurring workforce and capacity development opportunities in a variety of formats:

• Coordinator trainings to increase prevention providers' capacity to implement the Washington Strategic Prevention Framework (SPF) model. These trainings include:
o New Coordinator Basic Training – overview of Community Prevention and Wellness Initiative and SPF Models.
o Community Data Book Training – how to use data to conduct a community needs assessment.
o Goals, Objectives, Strategy Selection Training – how to prioritize local conditions and intervening variables to select program objectives and outcomes.
o Evaluation Training – how to conduct an evaluation of programs and use results
o CADCA Boot Camp – a four-day, interactive training to increase providers' capacity for coalition development.
• Annual Training: DBHR hosts two state-wide conferences for prevention professional and community partner capacity building and youth prevention team capacity building.
o These conferences provide educational and culturally competent training and networking opportunities for individuals and groups active in the field of prevention, including youth, volunteers, and prevention professionals. DBHR prevention staff participate both as presenters and attendees.
• Monthly Training: DBHR hosts on-going, optional monthly training sessions during the 3rd hour of the on-line monthly CPWI Learning Community Meetings attended by sub-recipients.
o Webinar training topics include emerging research and data as well as information on evidence-based practices and strategies to support program implementation.

• DBHR Technical Assistance Training and On-going Support:
o DBHR provides regular and timely Technical Assistance to CPWI communities covering:
? Budgeting;
? Strategic plan development;
? Action plan updates;
? SPF implementation;
? Contract compliance; and
? The Substance User Disorder Prevention and Mental Health Promotion Online Management Information System (MIS);
o In addition to live technical assistance, DBHR provides access to all training materials, shared documents, a calendar of events, and other resources on our workforce development and capacity development website, www.theAthenaForum.org.

3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies? ◉ Yes ○ No

a) If yes, please describe mechanism used.

Yes. Washington has a formal mechanism to assess community readiness in collaboration with WA counties, Educational Service Districts (ESDs), and communities. DBHR joins with key partners and stakeholders to work with the highest need communities to follow a selection process that would identify if the communities were at a high enough level of readiness. This readiness was assessed by community support for developing and implementing the CPWI. This was determined by documenting support from at least eight (8) of the twelve (12) required community representative sectors that serve or live in the defined community and agree to join the coalition. Additionally, School District support was assessed and documented to leverage funding to support the required match costs for the Prevention/ Intervention specialist in the middle and or high school in the community. If a community was determined to not have enough readiness, the next highest need community was assessed for readiness. DBHR uses a request for application (RFA) process through which high-risk communities apply for funding which includes assessing community readiness DBHR monitors readiness in an ongoing way using a community progress tool and a community assessment tool.

4. Does your state integrate the National CLAS Standards into the capacity building step? ◉ Yes ○ No

a) If yes, please explain in the box below.

The DBHR Prevention Section integrates the CLAS standards into the building capacity phase for Community Prevention and Wellness Initiative (CPWI) community and school-based providers including but not limited to:
• Incorporating these standards and expectations into the contract language that is negotiated prior the planning and implementation of programs and strategies that states:
o Services and Activities to Diverse Populations:
? Contractor shall ensure all services and activities provided by Contractor or subcontractor under this Contract shall be designed and delivered in a manner sensitive to the needs of all diverse populations.
? Contractor shall initiate actions to ensure or improve access, retention, and cultural relevance of prevention or other appropriate services, diverse populations in need of prevention services as identified in their needs assessment.
? Contractor shall take the initiative to strengthen working relationships with other agencies serving these populations. Contractor shall require its subcontractors to adhere to these requirements.
• The contract language also incorporates the Substance Abuse and Mental Health Services Administration (SAMHSA) Award Terms that state:
o Civil Rights Laws that prohibit discrimination:
? You must administer your project in compliance with federal civil rights laws that prohibit discrimination on the basis of race, color, national origin, disability, age and, in some circumstances, religion, conscience, and sex (including gender identity, sexual orientation, and pregnancy). This includes taking reasonable steps to provide meaningful access to persons with limited English proficiency and providing programs that are accessible to and usable by persons with disabilities. The HHS Office for Civil Rights provides guidance on complying with civil rights laws enforced by HHS. See https://www.hhs.gov/civil-rights/for-providers/providerobligations/index.html and https://www.hhs.gov/civil-rights/forindividuals/nondiscrimination/index.html.
? You must take reasonable steps to ensure that your project provides meaningful access to persons with limited English proficiency. For guidance on meeting your legal obligation to take reasonable steps to ensure meaningful access to your programs or activities by limited English proficient individuals, see https://www.hhs.gov/civilrights/for-individuals/special-topics/limited-english-proficiency/fact-sheetguidance/index.html and https://www.lep.gov.
? For information on your specific legal obligations for serving qualified individuals with disabilities, including providing program access, reasonable modifications, and taking appropriate steps to provide effective communication, see http://www.hhs.gov/ocr/civilrights/understanding/disability/index.html.
? HHS funded health and education programs must be administered in an environment free of sexual harassment, see https://www.hhs.gov/civil-rights/for-individuals/sexdiscrimination/index.html.
? For guidance on administering your project in compliance with applicable federal religious nondiscrimination laws and applicable federal conscience protection and associated anti-discrimination laws, see https://www.hhs.gov/conscience/conscienceprotections/index.html and https://www.hhs.gov/conscience/religiousfreedom/index.html.
• Requiring diverse representation on the community coalition as membership is being established that is representative

of the community being served to include a minimum of 8 of the following 12 sectors who serve as members:
1. Youth
2. Parent
3. Law Enforcement
4. Civic/Volunteer Groups
5. Business
6. Healthcare Professionals
7. Media
8. School
9. Youth-Service Organizations
10. Religious/Fraternal Organizations
11. State/Local/Tribal Governments
12. Other Substance Use Disorder Organizations
• Providing training and technical assistance that is offered in a variety of different formats to include through in-person and virtual/hybrid events to enhance community readiness and increase prevention knowledge.

5. Does your state integrate sustainability into the capacity building step? ◉ Yes ○ No

a) If yes, please explain in the box below.

Sustainability is also integrated in a variety of different ways in the capacity building through CPWI to include, but not limited to:
• Providing technical assistance and training opportunities to providers to assist with their efforts on increasing the skills, knowledge, and abilities for organizations and individuals involved in CPWI to ensure they are able to sustain their efforts and engagement. This includes training provided directly by DBHR prevention staff as well as by allowing funding to support additional training attendance and efforts.
• Increasing public awareness and buy-in through various methods of communication done at the local community level that is either required or strongly encouraged to include through Town Hall and/or Key Leader Events as well as through various DBHR sponsored publications that speak to prevention science and CPWI.

b) If no, please explain in the box below.

Narratve Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
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5. ***Community-based Processes*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Planning

1. Does your state have a strategic plan that addresses substance use primary prevention that was developed within the last five years? (●) Yes ( ) No

If yes, please attach the plan in BGAS by going to the **Attachments Page** and upload the plan.

Yes. The first State of Washington Substance Abuse and Mental Health Promotion Five-Year Strategic Plan was developed in 2012. It was updated in 2015,2017, and 2019. A new 2023-2027 Strategic Plan is in process, set to be printed in July 2023. Past plans are posted at www.TheAthenaForum.org/spe. This strategic plan guides and coordinates the substance use disorder prevention and mental health promotion efforts across WA state agencies.

2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SUPTRS BG? (●) Yes ( ) No ( ) N/A

3. Does your state's prevention strategic plan include the following components? (check all that apply):

- **a)** [x] Based on needs assessment datasets the priorities that guide the allocation of SUPTRS BG primary prevention funds
- **b)** [x] Timelines
- **c)** [x] Roles and responsibilities
- **d)** [x] Process indicators
- **e)** [x] Outcome indicators
- **f)** [x] Cultural competence component (i.e., National CLAS Standards)
- **g)** [x] Sustainability component
- **h)** [x] Other (please list):

  1. Resource assessment.
  2. Prevention research theories.
  3. Workforce development goals.
  4. Prevention/SUD policy tracking/review.
- **i)** [ ] Not applicable/no prevention strategic plan

4. Does your state have an Advisory Council that provides input into decisions about the use of SUPTRS BG primary prevention funds? (●) Yes ( ) No

5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate (●) Yes ( ) No

strategies to be implemented with SUPTRS BG primary prevention funds?

a) If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based

Yes. Washington State's Evidence-Based Program Workgroup (EBP Workgroup) determines a list of evidence-based programs and strategies that our sub-recipients for primary prevention services are permitted to select from. The list is posted on the Athena Forum website (https://www.TheAthenaForum.org/EBP). The EBP Workgroup is comprised of researchers and experts within and outside of Washington state, from University of Washington's Social Development Research Group and Washington State University's Improving Prevention through Action Research Lab, with input from the Washington State Institute for Public Policy, the prevention research sub-committee, and Pacific Institute for Research and Evaluation. The programs and strategies on the list originally come from three primary resources: the National Registry for Evidence-based Programs and Practices (NREPP), a separate list of programs identified as evidence-based by the State of Oregon; and the Pacific Institute for Research and Evaluation's (PIRE) "Scientific Evidence for Developing a Logic Model on Underage Drinking: A Reference Guide for Community Environmental Prevention" report. The list continues to be updated through a review of evidence informed by several evidence-based registries and reports, including Blueprints for Healthy Youth Development, California Evidence Based Clearinghouse, CrimeSolutions, and the Washington State Institute for Public Policy's various inventories of evidence-based and research-based child welfare and juvenile justice prevention programs.

6. Does your state have an Advisory Council that provides input into decisions about the use of SUPTRS BG primary prevention funds? (●) Yes ( ) No

7. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SUPTRS BG primary prevention funds? (●) Yes ( ) No

a) If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based?

Yes. Washington State's Evidence-Based Program Workgroup (EBP Workgroup) determines a list of evidence-based programs and strategies that our sub-recipients for primary prevention services are permitted to select from. The list is posted on the Athena Forum website (https://www.TheAthenaForum.org/EBP). The EBP Workgroup is comprised of researchers and experts within and outside of Washington state, from University of Washington's Social Development Research Group and Washington State University's Improving Prevention through Action Research Lab, with input from the Washington State Institute for Public Policy, the prevention research sub-committee, and Pacific Institute for Research and Evaluation. The programs and strategies on the list originally come from three primary resources: the National Registry for Evidence-based Programs and Practices (NREPP), a separate list of programs identified as evidence-based by the State of Oregon; and the Pacific Institute for Research and Evaluation's (PIRE) "Scientific Evidence for Developing a Logic Model on Underage Drinking: A Reference Guide for Community Environmental Prevention" report. The list continues to be updated through a review of evidence informed by several evidence-based registries and reports, including Blueprints for Healthy Youth Development, California Evidence Based Clearinghouse, CrimeSolutions, and the Washington State Institute for Public Policy's various inventories of evidence-based and research-based child welfare and juvenile justice prevention programs.

8. Does your state integrate the National CLAS Standards into the planning step? (●) Yes ( ) No

a) If yes, please explain in the box below.

The DBHR Prevention Section integrates the CLAS standards into the planning phase for Community Prevention and Wellness Initiative (CPWI) community and school-based providers including but not limited to:
• Requiring 8 of 12 diverse sectors to be represented and engaged in coalition meetings at least 9 months out of the year to ensure the broader community voice, that is representative of the community as well as the identified populations of focus, are included in planning efforts.
• Requiring CPWI coalitions to outline how the coalition will ensure inclusion and participation of members, address health disparities, and implementation of National Culturally and Linguistically Appropriate Services (CLAS) Standards within a strategic plan that includes a logic model that identifies health disparities as a long-term outcome. Coalitions are also required to review their mission, goals, activities, budget, and strategies annually.
• Requiring program strategy selection based upon prioritized risk and/or protective factors that are informed through Data Books, provided to communities by DBHR, based upon the results from the biennial statewide Healthy Youth Survey and other archival data.
• Contract language that requires minimum standards for Evidence-Based Programs while also allowing for adaptation an innovation to meet community and cultural needs.

b) If no, please explain in the box below.

N/A

9. Does your state integrate sustainability into the planning step? (●) Yes ( ) No

a) If yes, please explain in the box below.

a. Sustainability is integrated into the planning step including, but not limited to, requiring CPWI coalitions in their strategic planning process to think about and identify a comprehensive approach. This approach must meet the needs of

the community, be within their capacity, and ensure the coalition is identifying the appropriate programs and strategies for the priority populations being served. As part of the strategic planning process, the unique culture of each community is identified and discussed as well as the ability to plan for continuation of funding especially in circumstances where funding is time limited.

b) If no, please explain in the box below.

N/A

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The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***Problem Identification and Referral*** that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. ***Community-based Processes*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Implementation

1. States distribute SUPTRS BG primary prevention funds in a variety of different ways. Please check all that apply to your state:

- **a)** ☑ SSA staff directly implements primary prevention programs and strategies.
- **b)** ☑ The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).
- **c)** ☑ The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.
- **d)** ☐ The SSA funds regional entities that provide training and technical assistance.
- **e)** ☐ The SSA funds regional entities to provide prevention services.
- **f)** ☑ The SSA funds county, city, or tribal governments to provide prevention services.
- **g)** ☑ The SSA funds community coalitions to provide prevention services.
- **h)** ☑ The SSA funds individual programs that are not part of a larger community effort.
- **i)** ☑ The SSA directly funds other state agency prevention programs.
- **j)** ☐ Other (please describe)

2. Please list the specific primary prevention programs, practices, and strategies that are funded with SUPTRS BG primary prevention dollars in at least one of the six prevention strategies. Please see the introduction above for definitions of the six strategies:

a) Information Dissemination:

SABG funding will continue to support efforts to raise awareness of risks associated with substance use and promote protective factors within communities. Prevention providers also promote local efforts and strategies.

b) Education:

SABG funding will continue to support prevention services that provide education and communication from educators/facilitators to program participants (e.g., caregivers, youth, parents etc.) according to annual plans. This includes evidence-based parenting workshops, direct-service prevention programs for youth, and seminars/workshops.

c) Alternatives:

SABG funding will continue to support substance-free activities, especially for youth. These activities provide safe and adult-monitored spaces for youth and teens, often in communities that do not have many other options for teens. These activities often also provide consistent and supportive relationships with other adults in the community (e.g., community center staff, etc.). Alternative activities are often used to complement or in conjunction with educational programs and

strategies.

d) Problem Identification and Referral:

SABG funding will continue to support prevention/intervention staff (i.e., Student Assistance Professionals) in CPWI community schools. The Student Assistance Prevention-Intervention Services Program (SAPISP) is a comprehensive, integrated model of services that fosters safe school environments, promotes healthy childhood development and prevents alcohol, tobacco, and other drug abuse. Services include:
• Screening for high-risk behaviors.
• Consultation for parents and staff.
• Referrals to community services.
• Case management with school team.
• School-wide prevention activities.
• Professional consultation services.
• Informational workshops for parents, school staff, and community members. ?

e) Community-Based Processes:

SABG supports the daily and ongoing coordination work of the Community Coalition Coordinator that staffs and supports the local (required) community coalition delivering substance use prevention services through the Community Prevention and Wellness Initiative (CPWI). Funding for this category also supports Tribal staff to implement prevention programs via Indian Nation Agreements.

f) Environmental:

SABG funds will continue to support the implementation of strategies that impact community-level change. Strategies focus on community norms, policies, and aspects of the built environment that impact availability, access, and enforcement to prevent youth substance use.
The following table displays the primary prevention programs, practices, and strategies funded with SABG primary prevention dollars in each of the six prevention categories.

CSAP Category Program Name
Alternatives Tribal Traditional Teaching
Alternatives Big Brothers Big Sisters Mentoring Program
Alternatives Community Coalition
Alternatives Gathering of Native Americans
Alternatives Career Beginnings Mentoring Program
Community-Based Process Community Coalition
Community-Based Process Gathering of Native Americans
Community-Based Process Youth Prevention Group
Community-Based Process Communities That Care
Education Strengthening Families Program: for Parents and Youth 10-14 (Iowa)
Education Lions Quest Skills for Adolescence
Education Life Skills Training Program (LST)
Education Curriculum Based Support Group Program (CBSG)
Education Incredible Years
Education Class Action
Education Project ALERT
Education Hip-Hop 2 Prevent Substance Abuse and HIV (H2P)
Education SPORT
Education Positive Action
Education Other-Innovative
Education Reconnecting Youth
Education Community Coalition
Education Guiding Good Choices
Education Parenting Wisely
Education Too Good for Drugs
Education Second Step
Education Project Northland
Education Alcohol Literacy Challenge (ALC)
Education Nurse Family Partnership
Education Al's Pals: Kids Making Healthy Choices
Education Character Strong
Education Love and Logic
Education Keep a Clear Mind
Education Children in Between
Education I Can Problem Solve
Education Strengthening Families Program (Utah)
Environmental Policy Review and Development

Environmental Social Host Ordinance
Environmental Compliance Checks
Environmental School Policies
Environmental Advertising Restrictions
Environmental Tobacco-Free Environmental Policies
Information Dissemination Good Behavior Game
Information Dissemination Public Awareness Campaign
Information Dissemination Social Norms Marketing
Problem Identification and Referral Project Success

Additionally, DBHR uses SABG funds for programs that have been identified as Other-Innovative in two of the six CSAP categories such as those below:

CSAP Category Program Name
Alternatives Other-Innovative
Environmental Other-Innovative
Education Other-Innovative

3. Does your state have a process in place to ensure that SUPTRS BG dollars are used only to fund primary prevention services not funded through other means? ◉ Yes ○ No

a) If yes, please describe.

In addition to the SABG, the State of Washington provides only a small amount of funds for prevention, which does not meet the state's prevention needs. To ensure compliance, DBHR's Prevention System Managers (PSMs) monitor expenditures to ensure that SABG dollars are used as required by the grant. DBHR's contracts specify approved uses of these funds and PSMs engage in routine monitoring activities to ensure alignment with these requirements.

4. Does your state integrate National CLAS Standards into the implementation step? ◉ Yes ○ No

a) If yes, please describe in the box below.

The DBHR Prevention Section integrates the CLAS standards into the implementation phase for Community Prevention and Wellness Initiative (CPWI) community and school-based providers including but not limited to expectations that providers are:
• Implementing programs and strategies in a sensitive and relevant manner to the populations of focus that are experiencing the highest number of health disparities.
• Involving members of the population of focus in the implementation of the programing including as the facilitator.
• Adapting curriculum as needed to be culturally relevant.
• Providing programs and materials in different languages with different translations as appropriate for their community.

During the implementation phase, site visits are also completed by DBHR staff to evaluate the implementation of strategies to address health equity and cultural competency using the following metrics; (1) the identification of disparities using a data-informed approach, including through the needs assessment; (2) the CPWI coalition is representative of the diversity of the community; (3) successful implementation of programs and strategies as outlined in the strategic plan that ensure or improve access, retention, and cultural relevance in a manner that meets the needs of all racial/ethnic, minority, and other diverse populations, as well as underserved persons within the community.

b) If no, please explain in the box below.

5. Does your state integrate sustainability into the implementation step? ◉ Yes ○ No

a) If yes, please describe in the box below.

Sustainability is integrated in the implementation step for CPWI providers including but not limited to, implementing Evidence-Based Programs with a focus on engagement and retention as well as celebrating success throughout implementation to help demonstrate to community members the importance of prevention programming. CPWI coalitions are also required to implement ongoing, annual, recurring services and use leveraged funds, in-kind donations, and other resources to ensure the continuation of implementation.

b) If no, please explain in the box below

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In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Evaluation

1. Does your state have an evaluation plan for substance use primary prevention that was developed within the last five years? (●) Yes ( ) No

If yes, please attach the plan in BGAS by going to the **Attachments Page** and upload the plan.

DBHR contracts with Washington State University to evaluate the effectiveness of the Community Prevention and Wellness Initiative (CPWI). CPWI is a strategic, data-informed, community coalition model aimed at preventing youth alcohol, tobacco, marijuana, opioid, and other drug use by targeting prevention efforts in the highest risk communities throughout the state (there are currently 96 CPWI communities).

This evaluation approach addresses two specific questions:
1) How do 10th Grade substance use and risk factors in CPWI communities change over time? and
2) Are the changes/trends over time different for CPWI communities compared to similar non-CPWI communities in Washington State? The evaluation draws from the state Healthy Youth Survey as well as community-level program and evaluation data. In addition, this effort evaluates community readiness (to implement CPWI) and characteristics of successful coalitions. Results of these evaluations are disseminated to CPWI communities and other stakeholders through reports, community presentations, and consultations. The evaluations products include the following:
• Developmental Trend Analysis Report (State Level)
• Impact Over Time Outcome Report (State Level)
• Community Readiness Report (State Level)
• Characteristics of Successful Coalitions Report (State Level)
• Community-Level Evaluation Summary Reports (Community Level)
• Community-Level Roll-Up Evaluation Report (State Level)
• Additional reporting through regional and national conferences and publications

2. Does your state's prevention evaluation plan include the following components? (check all that apply):

- **a)** ☑ Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks
- **b)** ☑ Includes evaluation information from sub-recipients
- **c)** ☑ Includes SAMHSA National Outcome Measurement (NOMs) requirements
- **d)** ☑ Establishes a process for providing timely evaluation information to stakeholders
- **e)** ☑ Formalizes processes for incorporating evaluation findings into resource allocation and decision-making
- **f)** ☑ Other (please list:)

Reports to sub-recipients
Evaluation of trainings offered by DBHR.

g) ☐ Not applicable/no prevention evaluation plan

3. Please check those process measures listed below that your state collects on its SUPTRS BG funded prevention services:

a) ☑ Numbers served

b) ☑ Implementation fidelity

c) ☐ Participant satisfaction

d) ☑ Number of evidence based programs/practices/policies implemented

e) ☑ Attendance

f) ☑ Demographic information

g) ☑ Other (please describe):

1. Service hours.
2. Number of Visitors to Table/Booth or Event.
3. Number of Pick Ups/Destruction Trips.
4. Number of Reverse Distributor Mailers Distributed.
5. Number of Lock Boxes Distributed.
6. Number of Pounds Collected.
7. Number of materials distributed.
8. Number of People Reached by Radio Media Disseminated
9. Number of People Reached by TV
10. Number of People Reach By Newspaper/Press Release/Magazine Disseminated
11. Number of People Reach By Poster/Stickers Disseminated
12. Number of People Reach By Billboard Disseminated
13. Number of People Reached By Events
14. Number of Events
15. Number Users of Webpage
16. Number Unique Page Views of Webpage
17. Enter Number Followers on Social Media
18. Number of Social Media Posts (FB, Twitter, Etc) on Social Media
19. Number Clicked Post/Tweet (From All Posts/Tweets That Month) on Social Media
20. Number Who Reacted To Post To All Posts/Tweets (Liked/Shared/Commented) on Social Media
21. Social Media Display Ads
22. Enter Number of Website Clicks on Social Media Display Ads

4. Please check those outcome measures listed below that your state collects on its SUPTRS BG funded prevention services:

a) ☐ 30-day use of alcohol, tobacco, prescription drugs, etc

b) ☐ Heavy use

c) ☐ Binge use

d) ☐ Perception of harm

e) ☐ Disapproval of use

f) ☐ Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)

g) ☑ Other (please describe):

a. WA Department of Health:
i. Alcohol related injury/accident (hospitalization);
ii. Other drugs related injury/accident (hospitalization);
iii. Tobacco related deaths;
iv. Alcohol related deaths;
v. Other drug deaths – Drug related deaths; and
vi. Opioid related deaths – All Opioids; Prescription; Heroin.
b. Uniform Crime Reporting:
i. Arrests - Alcohol Violation;
ii. Arrests – Alcohol Related;
iii. Arrests – Drug Violation; and
iv. Arrests – Drug Related.
c. Office of Superintendent of Public Instruction:
i. High School Extended Graduation Rate (includes on-time graduation).
d. Comprehensive Hospital Abstract Reporting System (CHARS):
i. Suicide and attempts.
e. WA Department of Transportation and WA State Highway Safety Commission

i. Fatalities and Serious Injury from Crashes: Alcohol-Related Traffic Injuries and Alcohol-Related Traffic Fatalities.
f. Washington Healthy Youth Survey:
i. Underage Drinking (10th Grade);
ii. Marijuana Use (10th Grade);
iii. Use of Prescription Drugs Not Prescribed (10th Grade);
iv. Pain Killer Use to get High (10th Grade)
v. Tobacco Use (10th Grade);
vi. E-Cigarette/Vapor Products Use (10th Grade);
vii. Polysubstance Use (10th Grade);
viii. Sad/Hopeless in Past 12 Months (10th Grade);
ix. Suicide Ideation (10th Grade);
x. Suicide Plan (10th Grade);
xi. Suicide Attempt (10th Grade);
xii. Bullied/Harassed/Intimidated (10th Grade);
xiii. Source of Alcohol, Pain Killers Used to Get High; Marijuana; Vapor Products (10th Grade);
xiv. Perception of Availability of Alcohol, Marijuana, Cigarettes; Opioids (10th Grade);
xv. Risk Perception of Alcohol, Marijuana (10th Grade); and
xvi. Knowledge of Laws, Perception of Enforcement – Alcohol, Marijuana (10th Grade)
g. Washington Young Adult Health Survey:
i. Young Adult (18-25) Marijuana Use;
ii. Alcohol Use; and
iii. Source of Marijuana.
h. Pregnancy Risk Assessment Monitoring System (PRAMS):
i. Pregnant Women Report Alcohol Use Any Time During Pregnancy.
i. Washington State Liquor and Cannabis Control Board:
i. Count of State Liquor Licenses;
ii. Count of State Marijuana Store Licenses and Processor Licenses; and
iii. Monthly revenue/sales of products.

5. Does your state integrate the National CLAS Standards into the evaluation step? ◉ Yes ○ No

a) If yes, please explain in the box below.

The DBHR Prevention Section integrates the CLAS standards into the evaluation phase for Community Prevention and Wellness Initiative (CPWI) community and school-based providers including but not limited to:
• Implementation of Coalition Progress Questionnaire with all CPWI sites. This Questionnaire is a standardized assessment of the coalition’s current status to include: a review of data collection methods, with a specific review of the collection methodology of data on the numbers of all youth in the community, disaggregated by age, race, ethnicity, and sexual orientation, the number of youth within these demographics who were served, and any specific identified needs for improvement in addressing identified disparities in access to and utilization of prevention services.
• Prevention System Managers within the Section complete a monthly review of local data collection mechanisms in the Minerva reporting system, to determine if local methods to collect data and serve the needs of populations of focus are being utilized and ensure pre and post-test for program participants are completed.
• Annually, each CPWI site completes an internal coalition survey of members, called the Coalition Assessment Tool, to identify their perception of strengths and satisfaction with the progress of the coalition. The survey includes a section on cultural competence/health equity. Following annual administration of the survey each fall, results are analyzed and integrated into ongoing process improvement of programs and practices.
• Annually, CPWI coalitions complete a review of their progress achieving goals and objectives of their strategic plans followed by updates to the plans. Prevention System Managers provide technical assistance identifying whether the outcomes of programs demonstrate that they are effective, relevant for the identified groups of people receiving services, and whether adjustments to strategic plans need to be made for better outcomes for the entire community being served, including sub-populations and populations of focus within the larger community.
• Reports are also ran from the Minerva system that identifies the age, race, ethnicity, and sexual orientation of participants in prevention programs and activities that will help determine access to services correlated to demographics of participants. These reports are compared to the previously identified demographics of the community, and any disparities in services will be identified by the Prevention System Manager, with support from the project evaluators. Technical assistance is provided to the coalition coordinator to help identify the related issues and develop a plan to enhance services and eliminate existing disparities.

b) If no, please explain in the box below.

6. Does your state integrate sustainability into the evaluation step? ◉ Yes ○ No

a) If yes, please describe in the box below.

Sustainability is integrated into the evaluation step with CPWI providers including, but not limited to, reviewing the outcomes of programs and strategies implemented then focusing continuation efforts on those programs that were

effective. This also includes reviewing public awareness/campaign implementation to ensure the intended audience was reached. Sharing the data and sharing success stories with stakeholders and decision-makers within the community and local government to further highlight the success of prevention is also a strategy taken to further sustainability efforts due to limited resources.

b) If no, please explain in the box below.

Footnotes:

Environmental Factors and Plan

9. Statutory Criterion for MHBG - Required for MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Please respond to the following items

Criterion 1

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occuring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Contracts with Behavioral Health Administrative Service Organizations and Managed Care Organizations cover a wide variety of services in support of the individuals to live in their communities. Some examples of the services provided on a community level include crisis services, outpatient mental health counseling, group and family treatment, medication management, and medication monitoring. There is also higher level of outpatient resources such as intensive services for youth and families, respite services, the program of assertive community treatment (PACT), and high intensity services. Additional services to support individuals in the community include care coordination, engagement and outreach services, housing and recovery through peer services, mental health club houses, as well as supported employment.

2. Does your state coordinate the following services under comprehensive community-based mental health service systems?

		Yes	No
a)	Physical Health	○	●
b)	Mental Health	●	○
c)	Rehabilitation services	●	○
d)	Employment services	●	○
e)	Housing services	●	○
f)	Educational Services	●	○
g)	Substance misuse prevention and SUD treatment services	●	○
h)	Medical and dental services	○	●
i)	Support services	●	○
j)	Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)	○	●
k)	Services for persons with co-occuring M/SUDs	●	○

Please describe or clarify the services coordinated, as needed (for example, best practices, service needs, concerns, etc.)

-

3. Describe your state's case management services

While generic case management services are not included in Washington's Medicaid State Plan, as part of individual treatment services, mental health practitioners provide a range of activities in the community to further an individual's rehabilitative treatment goals. Activities would include skill modeling and training, assistance with ADLs. Additionally, Washington does have a service "Rehabilitative Case Management" which focuses on facilitating discharges from treatment institutions back into their community. This service includes warm handoffs to a community mental health provider and follow-up as needed to mitigate the risk or re-hospitalization. Activities include assessment for discharge or admission to community mental health care, integrated mental health treatment planning, resource identification and linkage to mental health rehabilitative services, and collaborative development of individualized services that promote continuity of mental health care. These specialized mental health coordination activities are intended to promote discharge, to maximize the benefits of the placement and to minimize the risk of unplanned readmission, and to increase the community tenure of the individual.

4. Describe activities intended to reduce hospitalizations and hospital stays.

Ensuring the right amount of care is available at the right time is key to reducing the need for hospitalization. Washington State

requires each Behavioral Health Administrative Services Organization (BH ASO) and managed care entity within a designated region to ensure that a specific array of core mental health services are offered within the ASO and MCO's s network. These services span the continuum of care, ranging from less intensive outpatient services (i.e. therapeutic psychoeducation, brief intervention services, individual or group therapy), to more intensive multi-disciplinary team delivered services (i.e. Wraparound with Intensive Services, Program for Assertive Community Treatment), to more structured and stabilization focused care (i.e. mental health services in a residential setting, crisis stabilization services, evaluation and treatment in an inpatient setting). Peer support services are provided along the continuum of care, to promote a strength based and person-centered approach. Crisis outreach services and crisis support lines are offered on a 24/7 basis, always with the intention of offering the least restrictive alternative options to hospitalization. Washington State requires each BHO to meet and maintain network adequacy, appointment, response, and distance standards to ensure individuals have sufficient and timely access to care.

Appropriately decreasing the length of hospital stays and readmission rates hinges upon continuous and thorough discharge planning, as well as access to appropriate step-down options. Each BHO utilizes hospital liaisons within their region to assist with the discharge planning at the state hospitals, as well as the evaluation and treatment facilities. Washington State recently provided additional funding to the BH ASOs to further support dedicated discharge planners at the evaluation and treatment centers. Additionally, the state launched a Peer Bridger Pilot program that integrates peer counselors into each BH ASO hospital liaison team to facilitate discharge planning and to support successful transition and continuity of care as individuals return to their communities.

Appropriate step-down options are often hindered by a lack of safe and stable housing for individuals leaving a hospital setting. Washington has now entered into a five-year agreement with the Centers for Medicare and Medicaid Services (CMS) that provides federal funding for regional health system transformation projects. One of the three initiatives under this demonstration will focus on providing more supportive housing opportunities and services. It is anticipated that this increase in both funding and flexibility to help individuals with behavioral health needs obtain and maintain housing will bolster discharging efforts and enhance step down options.

Please indicate areas of technical assistance needed related to this section.

None at this time.

Criterion 2: Mental Health System Data Epidemiology

Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

Criterion 2

In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus.

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state's M/SUD system.

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1.Adults with SMI	103208	N/A
2.Children with SED	40319	N/A

Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

Data Source: BHDS, P1 claims assumed to reflect MH services in the FIMC regions using an HCA approved algorithm with known limitations.
Washington State does not have a methodology or data to estimate incidence rates.

Please indicate areas of technical assistance needed related to this section.

None at this time.

Criterion 3

Provides for a system of integrated services in order for children to receive care for their multiple needs. Does your state integrate the following services into a comprehensive system of care*?

a)	Social Services	○ Yes	● No
b)	Educational services, including services provided under IDEA	○ Yes	● No
c)	Juvenile justice services	○ Yes	● No
d)	Substance misuse preventiion and SUD treatment services	○ Yes	● No
e)	Health and mental health services	○ Yes	● No
f)	Establishes defined geographic area for the provision of services of such systems	● Yes	○ No

Please indicate areas of technical assistance needed related to this section.

None at this time.

**A system of care is: A spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life.*
https://gucchd.georgetown.edu/products/Toolkit_SOC_Resource1.pdf

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults

Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.

Criterion 4

a. Describe your state's targeted services to rural population. **See SAMHSA's Rural Behavioral Health page for program resources**

Washington State requires each Behavioral Health Administrative Services Organization (BH ASO) and managed care entities within a designated region to maintain an adequate provider network that meets the specific regional needs. For rural areas, the BH ASOs and MCOs must ensure that the location of their providers are within reasonable maximum distance standards. In addition, the state imposes access requirements through contract which requires the MCOs to provide community-based intake assessments at an individual's home or living facility, such as assisted living, adult family home, or skilled nursing facility.

b. Describe your state's targeted services to people experiencing homelessness. **See SAMHSA's Homeless Programs and Resources for program resources**

Washington State supports several programs throughout the state that provide targeted outreach to homeless individuals. Projects for Assistance in Transition from Homeless (PATH) provides persistent and consistent outreach to individuals experiencing homelessness to assist in accessing housing, behavioral health services, and other services to facilitate recovery and stabilization. Housing and Recovery through Peer Services (HARPS) is a team-based approach, utilizing certified peer counselors and mental health professionals to provide community-based services to at risk individuals. Priority populations for HARPS services include individuals who are homeless or at risk at becoming homeless, as well as individuals discharging from inpatient psychiatric settings.

c. Describe your state's targeted services to the older adult population. **See SAMHSA's Resources for Older Adults webpage for resources.**

Regarding serving the older adult population, the MCOs must provide or purchase age appropriate and culturally competent community behavioral health services for their enrollees whom services are medically necessary and clinically appropriate. Plans are required to analyze demographic data (including age) at least annually, to determine if their network is adequately serving the population of that region and to inform ongoing quality improvement. Providers within the networks are required to provide onsite intake assessments and services at assisted living facilities, skilled nursing facilities, and adult family homes when requested by either the individual or the facility. Washington State ensures that Preadmission Screening and Resident Review (PASRR) are conducted statewide to ensure that individuals with mental health needs referred to skilled nursing facilities are not inappropriately placed in nursing homes.

Please indicate areas of technical assistance needed related to this section.

None at this time.

Criterion 5: Management Systems

States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

Telehealth is a mode of service delivery that has been used in clinical settings for over 60 years and empirically studied for just over 20 years. Telehealth is not an intervention itself, but rather a mode of delivering services. This mode of service delivery increases access to screening, assessment, treatment, recovery supports, crisis support, and medication management across diverse behavioral health and primary care settings. Practitioners can offer telehealth through synchronous and asynchronous methods. A priority topic for SAMHSA is increasing access to treatment for SMI and SUD using telehealth modalities. Telehealth is the use of telecommunication technologies and electronic information to provide care and facilitate client-provider interactions. Practitioners can use telehealth with a hybrid approach for increased flexibility. For instance, a client can receive both in-person and telehealth visits throughout their treatment process depending on their needs and preferences. Telehealth methods can be implemented during public health emergencies (e.g., pandemics, infectious disease outbreaks, wildfires, flooding, tornadoes, hurricanes) to extend networks of providers (e.g., tapping into out-of-state providers to increase capacity). They can also expand capacity to provide direct client care when in-person, face-to-face interactions are not possible due to geographic barriers or a lack of providers or treatments in a given area. However, implementation of telehealth methods should not be reserved for emergencies or to serve as a bridge between providers and rural or underserved areas. Telehealth can be integrated into an organization's standard practices, providing low-barrier pathways for clients and providers to connect to and assess treatment needs, create treatment plans, initiate treatment, and provide long-term continuity of care. States are encouraged to access, the SAMHSA Evidence Based Resource Guide, **Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders**.

Criterion 5

a. Describe your state's management systems.

DBHR uses MHBG funds to purchase and provide training to community mental health providers across the state. Examples of training include: training in PACT fidelity and technical assistance and those EBPs included in the PACT model (CBT, Supported Employment, and Supportive Housing), Supportive Housing, Supported Employment, and Cognitive Behavioral Therapy for Psychosis. DBHR also purchases training for increasing the workforce of Certified Peer Counselors and provides training for Designated Mental Health Professionals who are responsible for providing on-site emergency evaluations of individuals who may need voluntary or involuntary treatment. Since April 1, 2018, these individuals have also been responsible for responding to emergencies with either mental health issues or issues revolving around substance use disorders. We trained the entire statewide work force in conducting SUD evaluations and co-occurring evaluations for voluntary and involuntary treatment.

b. Describe your state's current telehealth capabilities, how your state uses telehealth modalities to treat individuals with SMI/SED, and any plans/initiatives to expand its use.

Washington State allows telehealth to be used for any behavioral health encounter if it is HIPAA compliant. Additionally, audio only telehealth is allowed based off Washington State House Bill 1196 language of "safely and effectively delivered" to be used for all encounters except residential, intake assessment, and group treatment.

Prior to the Public Health Emergency (PHE) caused by the Coronavirus, the Health Care Authority had a robust telemedicine policy but was minimally utilized. Telehealth moved and evolved within Washington state very quickly due to the PHE, including rapid policy change to support the continuation of care during the PHE, including Washington Administrative Code (WAC) created to simplify the 3 existing WACs into one telemedicine WAC which also aligns with recent legislative direction, direct support of telemedicine for providers and patients, as well as collaboration with partners in telehealth. The Health Care Authority provided thousands of Zoom licenses to providers during the Coronavirus PHE to assist with implementation of telehealth.

Our current policies fully support the delivery of services via telehealth, audio visual or audio only, and we require these services to be paid at parity with in-person services.

Washington has leaned into the benefits and ability to reach further populations with telehealth technology and will be thoughtful on continuing to focus on the growth and expansion of telehealth as safety and efficacy are clarified. Washington's need currently is on education and training for providers to meet the needs of individuals seeking behavioral health services that have access and transportation challenges.

Please indicate areas of technical assistance needed related to this section.

None at this time.

Footnotes:

Wraparound with Intensive Services (WISe), a service delivery model, provides children and youth service coordination to receive care for their multiple needs. WISe is designated to provide comprehensive behavioral health services and supports to Medicaid eligible individuals, up to 21 years of age with complex behavioral health needs. Youth with complex needs are usually involved in more than one child serving system such as child welfare, juvenile justice, social services and education. WISe requires referral and coordination with various services and systems. WISe also requires a single Cross System Care Plan based on the child/youth individual needs and the other child serving systems involved in their lives.

Environmental Factors and Plan

10. Substance Use Disorder Treatment - Required SUPTRS BG

Narrative Question

Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs

Criterion 1

Improving access to treatment services

1. Does your state provide:

a) A full continuum of services

i)	Screening	◉ Yes ○ No
ii)	Education	◉ Yes ○ No
iii)	Brief Intervention	◉ Yes ○ No
iv)	Assessment	◉ Yes ○ No
v)	Detox (inpatient/residential)	◉ Yes ○ No
vi)	Outpatient	◉ Yes ○ No
vii)	Intensive Outpatient	◉ Yes ○ No
viii)	Inpatient/Residential	◉ Yes ○ No
ix)	Aftercare; Recovery support	◉ Yes ○ No

b) Services for special populations:

i)	Prioritized services for veterans?	◉ Yes ○ No
ii)	Adolescents?	◉ Yes ○ No
iii)	Older Adults?	○ Yes ◉ No

Criterion 2

Criterion 3

1.	Does your state meet the performance requirement to establish and/or maintain new programs or expand programs to ensure treatment availability?	◉ Yes ○ No
2.	Does your state make prenatal care available to PWWDC receiving services, either directly or through an arrangement with public or private nonprofit entities?	◉ Yes ○ No
3.	Have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care?	◉ Yes ○ No
4.	Does your state have an arrangement for ensuring the provision of required supportive services?	◉ Yes ○ No

5 Has your state identified a need for any of the following:

a)	Open assessment and intake scheduling	◉ Yes ○ No
b)	Establishment of an electronic system to identify available treatment slots	◉ Yes ○ No
c)	Expanded community network for supportive services and healthcare	◉ Yes ○ No
d)	Inclusion of recovery support services	◉ Yes ○ No
e)	Health navigators to assist clients with community linkages	◉ Yes ○ No
f)	Expanded capability for family services, relationship restoration, and custody issues?	◉ Yes ○ No
g)	Providing employment assistance	◉ Yes ○ No
h)	Providing transportation to and from services	◉ Yes ○ No
i)	Educational assistance	○ Yes ◉ No

6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

Strategies for prioritizing pregnant individuals are contained within the contract language between the state of Washington and the Managed Care Organizations (MCOs). The MCOs must publicize the availability of treatment services to PPW clients at the facilities, as well as the fact that PPW clients receive priority admission.

The MCOs work with agencies to get pregnant individuals into services within 24 hours, and if a residential placement is not available interim services are provided. If residential treatment is not needed, the individual is enrolled in outpatient treatment. When services are not available, the provider is required to ensure the following:

• Provision of, referral to, or counseling on the effects of alcohol and drug use on the fetus.

• Referral to prenatal care.

• Provision of, or referral to, human immunodeficiency (HIV) and tuberculosis (TB) education.

• Referral for HIV or TB treatment services if necessary.

• PPW receiving treatment are treated as a family unit.

The following services are provided directly or arrangements are made for the provision of the following services with sufficient case management and transportation to ensure women and their children have access to services provided below:

• Primary medical care for women, including referral for prenatal care and childcare while the women are receiving such services.

• Primary pediatric care including immunization for their children.

• Gender specific SUD treatment and other therapeutic interventions for women which may address issues of relationships, sexual and physical abuse, and parenting are provided.

• Provide, directly or through arrangements with other public or nonprofit private entities, childcare to individuals participating in assessment and treatment activities, and supportive activities such as support groups, parenting education, and other supportive

activities when those activities are recommended as part of the recovery process noted in the individual's treatment plan.

• Therapeutic interventions for children in custody of individuals who identify as women treatment which may, among other things, address their developmental needs, their issues of sexual abuse and neglect.

• Substance Used Disorder Assessment Services specific to PPW.

• Services specific to Post-Partum Women.

• Services may continue to be provided for up to one year postpartum.

The MCOs must ensure assessment requirements in addition to standard assessment service, to include a review of the gestational age of fetus, mother's age, living arrangements, and family support data.

A pregnant woman who is unable to access residential treatment due to lack of capacity and is in need of detoxification, can be referred to a Chemical Using Pregnant (CUP) program for admission, typically within 24 hours.

Criterion 4,5&6

Persons Who Inject Drugs (PWID)

1. Does your state fulfill the:

a)	90 percent capacity reporting requirement	(●) Yes ( ) No
b)	14-120 day performance requirement with provision of interim services	(●) Yes ( ) No
c)	Outreach activities	(●) Yes ( ) No
d)	Syringe services programs, if applicable	(●) Yes ( ) No
e)	Monitoring requirements as outlined in the authorizing statute and implementing regulation	(●) Yes ( ) No

2. Has your state identified a need for any of the following:

a)	Electronic system with alert when 90 percent capacity is reached	( ) Yes (●) No
b)	Automatic reminder system associated with 14-120 day performance requirement	( ) Yes (●) No
c)	Use of peer recovery supports to maintain contact and support	(●) Yes ( ) No
d)	Service expansion to specific populations (e.g., military families, veterans, adolescents, LGBTQI+, older adults)?	( ) Yes (●) No

3. States are required to monitor program compliance related to activites and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

Strategies for prioritizing persons who inject drugs (PWID) is contained within the contract language between the state of Washington and the MCOs. The MCOs must publicize the availability of treatment services to PWID at the facilities, as well as the fact that PWID receive priority admission. In addition, the MCOs must ensure that outreach is provided to priority populations. The outreach activities must be specifically designed to reduce transmission of HIV and encourage PWID to undergo treatment.

If treatment services are not immediately available, then interim services are made available until an individual is admitted to a substance abuse treatment program. The purpose of the service is to reduce the adverse health effects of such abuse, promote the health of the individual, and reduce the risk of transmission of the disease.

The MCOs are required to submit a yearly project plan on how the services and the requirements in the contract will be adhered to. The project plans are reviewed and approved by DHBR. The MCOs are required to submit annual progress reports that include what outreach models were used to PWID to enter treatment.

Tuberculosis (TB)

1. Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery? (●) Yes ( ) No

2. Has your state identified a need for any of the following:

a)	Business agreement/MOU with primary healthcare providers	(●) Yes ( ) No
b)	Cooperative agreement/MOU with public health entity for testing and treatment	(●) Yes ( ) No
c)	Established co-located SUD professionals within FQHCs	( ) Yes (●) No

3. States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

The MCOs must directly or through arrangement with other public entities, make tuberculosis services available to individuals receiving SUD treatment. The services must include tuberculosis counseling, testing, and provide for or referring individuals infected with tuberculosis for appropriate medical evaluation and treatment.

In the case an individual in need of treatment services is denied admission to the tuberculosis program based on the lack of capacity the MCO will refer the individual to another provider of tuberculosis services. The MCOs must conduct case management activities to ensure the individual receives tuberculosis services.

Early Intervention Services for HIV (for "Designated States" Only)

1. Does your state currently have an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIV in areas that have the greatest need for such services and monitoring such service delivery? ○ Yes ◉ No

2. Has your state identified a need for any of the following:

- **a)** Establishment of EIS-HIV service hubs in rural areas ○ Yes ◉ No
- **b)** Establishment or expansion of tele-health and social media support services ◉ Yes ○ No
- **c)** Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS ○ Yes ◉ No

Syringe Service Programs

1. Does your state have in place an agreement to ensure that SUPTRS BG funds are NOT expended to provide individuals with hypodermic needles or syringes(42 U.S.CÂ§ 300x-31(a)(1)F)? ◉ Yes ○ No

2. Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program? ○ Yes ◉ No

3. Do any of the programs use SUPTRS BG funds to support elements of a Syringe Services Program? ○ Yes ◉ No

If yes, plese provide a brief description of the elements and the arrangement

N/A

Criterion 8,9&10

Service System Needs

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention and treatment authorized services available, identified gaps in service, and outlines the state's approach for improvement — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** Workforce development efforts to expand service access — (●) Yes ( ) No
- **b)** Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services — (●) Yes ( ) No
- **c)** Establish a peer recovery support network to assist in filling the gaps — (●) Yes ( ) No
- **d)** Incorporate input from special populations (military families, service memebers, veterans, tribal entities, older adults, sexual and gender minorities) — ( ) Yes (●) No
- **e)** Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, i.e. primary healthcare, public health, VA, community organizations — ( ) Yes (●) No
- **f)** Explore expansion of services for:
  - **i)** MOUD — (●) Yes ( ) No
  - **ii)** Tele-Health — (●) Yes ( ) No
  - **iii)** Social Media Outreach — (●) Yes ( ) No

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person -centered and person-directed care? — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services — (●) Yes ( ) No
- **b)** Establish a program to provide trauma-informed care — (●) Yes ( ) No
- **c)** Identify current and perspective partners to be included in building a system of care, such as FQHCs, primary healthcare, recovery community organizations, juvenile justice systems, adult criminal justice systems, and education — (●) Yes ( ) No

Charitable Choice

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (42 U.S.C.§ 300x-65, 42 CF Part 54 (§54.8(b) and §54.8(c)(4)) and 68 FR 56430-56449)? — (●) Yes ( ) No

2. Does your state provide any of the following:

- **a)** Notice to Program Beneficiaries — ( ) Yes (●) No
- **b)** An organized referral system to identify alternative providers? — (●) Yes ( ) No
- **c)** A system to maintain a list of referrals made by religious organizations? — ( ) Yes (●) No

Referrals

1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs? — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** Review and update of screening and assessment instruments — (●) Yes ( ) No
- **b)** Review of current levels of care to determine changes or additions — (●) Yes ( ) No

c) Identify workforce needs to expand service capabilities — ◉ Yes ○ No

d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background — ◉ Yes ○ No

Patient Records

1. Does your state have an agreement to ensure the protection of client records? — ◉ Yes ○ No

2. Has your state identified a need for any of the following:

   a) Training staff and community partners on confidentiality requirements — ◉ Yes ○ No

   b) Training on responding to requests asking for acknowledgement of the presence of clients — ◉ Yes ○ No

   c) Updating written procedures which regulate and control access to records — ◉ Yes ○ No

   d) Review and update of the procedure by which clients are notified of the confidentiality of their records including the exceptions for disclosure: — ◉ Yes ○ No

Independent Peer Review

1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers? — ◉ Yes ○ No

2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C.§ 300x-52(a)) and 45 § CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program involved.

   a) Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.

   The state completes an annual independent peer review of its providers. The BH-ASO regions are required to submit the names of providers who will be reviewed as well as independent peer reviewers from each of the regions in the state. The

   state has an administrative policy in place that defines the purpose and scope of the reviews. The plan for the FFY22 review will have 10 substance use treatment providers (10%) to be reviewed and 7 mental health providers (11%) to be reviewed. Reviews are happening during August and September 2023.

3. Has your state identified a need for any of the following:

   a) Development of a quality improvement plan — ◉ Yes ○ No

   b) Establishment of policies and procedures related to independent peer review — ◉ Yes ○ No

   c) Development of long-term planning for service revision and expansion to meet the needs of specific populations — ◉ Yes ○ No

4. Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, such as the Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds? — ○ Yes ◉ No

   If Yes, please identify the accreditation organization(s)

   i) ☐ Commission on the Accreditation of Rehabilitation Facilities

   ii) ☐ The Joint Commission

   iii) ☐ Other (please specify)

   N/A

Criterion 7&11

Group Homes

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program? ◉ Yes ○ No
2. Has your state identified a need for any of the following:
   - a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service ◉ Yes ○ No
   - b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing ◉ Yes ○ No

Professional Development

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opportunity to receive training on an ongoing basis, concerning:
   - a) Recent trends in substance use disorders in the state ◉ Yes ○ No
   - b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services ◉ Yes ○ No
   - c) Performance-based accountability: ◉ Yes ○ No
   - d) Data collection and reporting requirements ◉ Yes ○ No
2. Has your state identified a need for any of the following:
   - a) A comprehensive review of the current training schedule and identification of additional training needs ◉ Yes ○ No
   - b) Addition of training sessions designed to increase employee understanding of recovery support services ◉ Yes ○ No
   - c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services ◉ Yes ○ No
   - d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort ◉ Yes ○ No
3. Has your state utilized the Regional Prevention, Treatment and/or Mental Health Training and Technical Assistance Centers (TTCs)?
   - a) Prevention TTC? ◉ Yes ○ No
   - b) Mental Health TTC? ○ Yes ◉ No
   - c) Addiction TTC? ◉ Yes ○ No
   - d) State Targeted Response TTC? ○ Yes ◉ No

Waivers

Upon the request of a state, the Secretary may waive the requirements of all or part of the sections 1922(c), 1923, 1924. and 1928 (42 U.S.C.§ 300x-32 (f)).

1. Is your state considering requesting a waiver of any requirements related to:
   - a) Allocations regarding women ○ Yes ◉ No
2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus:
   - a) Tuberculosis ○ Yes ◉ No
   - b) Early Intervention Services Regarding HIV ○ Yes ◉ No
3. Additional Agreements
   - a) Improvement of Process for Appropriate Referrals for Treatment ○ Yes ◉ No

b) Professional Development ○ Yes ◉ No

c) Coordination of Various Activities and Services ○ Yes ◉ No

Please provide a link to the state administrative regulations that govern the Mental Health and Substance Use Disorder Programs.

https://apps.leg.wa.gov/wac/default.aspx?cite=182

If the answer is No to any of the above, please explain the reason.

Footnotes:

Environmental Factors and Plan

11. Quality Improvement Plan- Requested

Narrative Question

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2022-FFY 2023? ◯ Yes ◯ No

Please indicate areas of technical assistance needed related to this section.

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12. Trauma - Requested

Narrative Question

Trauma[1] is a common experience for adults and children in communities, and it is especially common in the lives of people with mental and substance use disorders. For this reason, the need to address trauma is increasingly seen as an important part of effective behavioral health care and an integral part of the healing and recovery process. It occurs because of violence, abuse, neglect, loss, disaster, war, and other emotionally harmful and/or life-threatening experiences. Trauma has no boundaries regarding age, gender, socioeconomic status, race, ethnicity, geography, ability, or sexual orientation. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in M/SUD services. People in the juvenile and criminal justice system and children and families in the child welfare system have high rates of mental illness, substance use disorders and personal histories of trauma. Similarly, many individuals in primary, specialty, emergency, and rehabilitative health care also have significant trauma histories, which impacts their health and responsiveness to health interventions. Also, schools are now recognizing that the impact of traumatic exposure among their students makes it difficult for students to learn and meet academic goals. As communities experience trauma, for some, these are rare events and for others, these are daily events. Children and families living in resource scarce communities remain especially vulnerable to experiences of trauma and thus face obstacles in accessing and receiving M/SUD care. States should work with these communities to identify interventions that best meet the needs of their residents. In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink how practices are conducted. These public institutions and service settings are increasingly adopting a trauma-informed approach distinct from trauma-specific assessments and treatments. Trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues with a focus on equity and inclusion. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma[2] paper.

[1] Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*

[2] *Ibid*

Please consider the following items as a guide when preparing the description of the state's system:

1. Does the state have a plan or policy for M/SUD providers that guides how they will address individuals with trauma-related issues? ○ Yes ○ No
2. Does the state provide information on trauma-specific assessment tools and interventions for M/SUD providers? ○ Yes ○ No
3. Does the state provide training on trauma-specific treatment and interventions for M/SUD providers? ○ Yes ○ No
4. Does the state have a plan to build the capacity of M/SUD providers and organizations to implement a trauma-informed approach to care? ○ Yes ○ No
5. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations? ○ Yes ○ No
6. Does the state use an evidence-based intervention to treat trauma? ○ Yes ○ No
7. Does the state have any activities related to this section that you would like to highlight.

Please indicate areas of technical assistance needed related to this section.

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13. Criminal and Juvenile Justice - Requested

Narrative Question

More than a third of people in prisons and nearly half of people in jail have a history of mental health problems.[1] Almost two thirds of people in prison and jail meet criteria for a substance use disorder.[2] As many as 70 percent of youth in the juvenile justice system have a diagnosable mental health problem.[3] States have numerous ways that they can work to improve care for these individuals and the other people with mental and substance use disorders involved in the criminal justice system. This is particularly important given the overrepresentation of populations that face mental health and substance use disorder disparities in the criminal justice system.

Addressing the mental health and substance use disorder treatment and service needs of people involved in the criminal justice system requires a variety of approaches. These include:

- Better coordination across mental health, substance use, criminal justice and other systems (including coordination across entities at the state and local levels);
- Data sharing and use of data to identify individuals in need of services, improve service delivery and coordination, and/or address disparities across racial and ethnic groups;
- Improvement of community capacity to provide MH and SUD services to people involved in the criminal justice system;
- Supporting the ability of law enforcement to respond to people experiencing mental illness or SUD (e.g. Crisis Intervention Teams, co-responder models, and coordinated police/emergency drop-off)
- Partnering with other state agencies and localities to improve screening and assessment for MH and SUD and standards of care for these illnesses for people in jails and prisons;
- Supporting coordination across community-based care and care in jails and prisons, particularly upon reentry into the community;
- Building crisis systems that engage people experiencing a MH or SUD related crisis in MH or SUD care instead of involvement with law enforcement and criminal justice (including coordination of 911 and 988 systems);
- Creating pathways for diversion from criminal justice to MH and SUD services throughout the criminal justice system (before arrest, at booking, jails, the courts, at reentry, and through community corrections);
- Coordination with juvenile court systems and development of programs to improve outcomes for children and youth involved in the juvenile justice system;
- Developing interventions during vulnerable periods, such as reentry to the community from jail or prison, to ensure that MH, SUD, and other needs are met;
- Addressing other barriers to recovery for people with M/SUD involved in the criminal justice system, such as health insurance enrollment, SSI/SSDI enrollment, homelessness and housing insecurity, and employment challenges;
- Partnering with the judicial system to engage in cross-system planning and development at the state and local levels;
- Providing education and support for judges and judicial staff related to navigating the mental health and substance use service system; and
- Supporting court-based programs, including specialty courts and diversion programs that serve people with M/ SUD.
- Addressing the increasing number of individuals who are detained in jails or state hospitals/facilities awaiting competence to stand trial assessments and restoration.

These types of approaches can improve outcomes and experiences for people with M/SUD involved in the criminal justice system and support more efficient use of criminal justice resources. The MHBG and SUPTRS BG may be especially valuable in supporting a stronger array of community-based services in these and other areas. SSAs and SMHAs can also play a key role in partnering with state and local agencies to improve coordination of systems and services. This includes state and local law enforcement, correctional systems, and courts. SAMHSA strongly encourages state behavioral health authorities to work closely with these partners, including their state courts, to ensure the best coordination of services and outcomes, especially in light of health disparities and inequities, and to develop closer interdisciplinary programming for justice system involved individuals. Promoting and supporting these efforts with a health equity lens is a SAMHSA priority.

[1]Bronson, J., & Berzofsky, M. (2017). Indicators of mental health problems reported by prisoners and jail inmates, 2011–12. Bureau of Justice Statistics, 1-16.

[2]Bronson, J., Stroop, J., Zimmer, S., & Berzofsky, M. (2017). Drug use, dependence, and abuse among state prisoners and jail inmates, 2007–2009. Washington, DC: United States Department of Justice, Office of Juvenile Justice and Delinquency Prevention.

[3]Vincent, G. M., Thomas Grisso, Anna Terry, and Steven M. Banks. 2008. "Sex and Race Differences in Mental Health Symptoms in Juvenile Justice: The MAYSI-2 National Meta-Analysis." Journal of the American Academy of Child and Adolescent Psychiatry 47(3):282–90.

Please respond to the following items

1. Does the state (SMHA and SSA) engage in any activities of the following activities:

- ☐ Coordination across mental health, substance use disorder, criminal justice and other systems
- ☐ Data sharing and use of data to identify individuals in need of services, improve service delivery and coordination, and/or address disparities across racial and ethnic groups
- ☐ Improvement of community capacity to provide MH and SUD services to people involved in the criminal justice system, including those related to medications for opioid use disorder
- ☐ Supporting the ability of law enforcement to respond to people experiencing mental illness or SUD (e.g. Crisis Intervention Teams, co-responder models, and coordinated police/emergency drop-off)
- ☐ Partnering with other state agencies and localities to improve screening and assessment for MH and SUD and standards of care for these illnesses for people in jails and prisons;
- ☐ Supporting coordination across community-based care and care in jails and prisons, particularly upon reentry into the community
- ☐ Building crisis systems that engage people experiencing a MH or SUD related crisis in MH or SUD care instead of involvement with law enforcement and criminal justice (including coordination of 911 and 988 systems)
- ☐ Creating pathways for diversion from criminal justice to MH and SUD services throughout the criminal justice system (before arrest, booking, jails, the courts, at reentry, and through community corrections)
- ☐ Coordination with juvenile court systems and development of programs to improve outcomes for children and youth involved in the juvenile justice system
- ☐ Developing interventions during vulnerable periods, such as reentry to the community from jail or prison, to ensure that MH, SUD, and other needs are met
- ☐ Addressing other barriers to recovery for people with M/SUD involved in the criminal justice system, such as health insurance enrollment, SSI/SSDI enrollment, homelessness and housing insecurity, and employment challenges
- ☐ Partnering with the judicial system to engage in cross-system planning and development at the state and local levels
- ☐ Providing education and support for judges and judicial staff related to navigating the mental health and substance use service system
- ☐ Supporting court-based programs, including specialty courts and diversion programs that serve people with M/SUD
- ☐ Addressing Competence to Stand Trial; assessments and restoration activities.

2. Does the state have any specific activities related to reducing disparities in service receipt and outcomes across racial and ethnic groups for individuals with M/SUD who are involved in the criminal justice system? If so, please describe. ○ Yes ○ No

3. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address M/SUD and other essential domains such as employment, education, and finances? ○ Yes ○ No

4. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

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14. Medications in the Treatment of Substance Use Disorders, Including Medication for Opioid Use Disorder (MOUD) – Requested (SUPTRS BG only)

Narrative Question

In line with the goals of the Overdose Prevention Strategy and SAMHSA's priority on Preventing Overdose, SAMHSA strongly request that information related to medications in the treatment of substance use disorders be included in the application.

There is a voluminous literature on the efficacy of the combination of medications for addiction treatment and other interventions and therapies to treat substance use disorders, particularly opioid, alcohol, and tobacco use disorders. This is particularly the case for medications used in the treatment of opioid use disorder, also increasingly known as Medications for Opioid Use Disorder (MOUD). The combination of medications such as MOUD; counseling; other behavioral therapies including contingency management; and social support services, provided in individualized, tailored ways, has helped countless number of individuals achieve and sustain remission and recovery from their substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based, or non-medication inclusive, treatment for these conditions. The evidence base for medications as standards of care for SUDs is described in SAMHSA TIP 49 Incorporating Alcohol Pharmacotherapies Into Medical Practice and TIP 63 Medications for Opioid Use Disorders.

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to offer MOUD and medications for alcohol use disorder or have collaborative relationships with other providers that can provide all FDA-approved medications for opioid and alcohol use disorder and other clinically needed services.

Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs. States should use Block Grant funds for the spectrum of evidence-based interventions for opioids and stimulants including medications for opioids use disorders and contingency management.

In addition, SAMHSA also encourages states to require equitable access to and implementation of medications for opioid use disorder (MOUD), alcohol use disorder (MAUD) and tobacco use disorders within their systems of care.

SAMHSA is asking for input from states to inform SAMHSA's activities.

Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding the use of medications for substance use disorders? ○ Yes ○ No

2. Has the state implemented a plan to educate and raise awareness of the use of medications for substance disorder, including MOUD, within special target audiences, particularly pregnant women? ○ Yes ○ No

3. Does the state purchase any of the following medication with block grant funds?

- **a)** ☐ Methadone
- **b)** ☐ Buprenophine, Buprenorphine/naloxone
- **c)** ☐ Disulfiram
- **d)** ☐ Acamprosate
- **e)** ☐ Naltrexone (oral, IM)
- **f)** ☐ Naloxone

4. Does the state have an implemented education or quality assurance program to assure that evidence-based treatment with the use of FDA-approved medications for treatment of substance use disorders is combined with other therapies and services based on individualized assessments and needs? ○ Yes ○ No

5. Does the state have any activities related to this section that you would like to highlight?

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15. Crisis Services – Required for MHBG, Requested for SUPTRS BG

Narrative Question

Substance Abuse and Mental Health Services Administration (SAMHSA) is directed by Congress to set aside 5 percent of the Mental Health Block Grant (MHBG) allocation for each state to support evidence-based crisis systems. The statutory language outlines the following for the 5 percent set-aside:

> *....to support evidenced-based programs that address the crisis care needs of individuals with serious mental illnesses and children with serious emotional disturbances, which may include individuals (including children and adolescents) experiencing mental health crises demonstrating serious mental illness or serious emotional disturbance, as applicable.*
>
> *CORE ELEMENTS: At the discretion of the single State agency responsible for the administration of the program, the funds may be used to expend some or all of the core crisis care service components, as applicable and appropriate, including the following:*
>
> - *Crisis call centers*
> - *24/7 mobile crisis services*
> - *Crisis stabilization programs offering acute care or subacute care in a hospital or appropriately licensed facility, as determined by such State, with referrals to inpatient or outpatient care.*
>
> *STATE FLEXIBILITY: In lieu of expanding 5 percent of the amount the State receives pursuant to this section for a fiscal year to support evidence based programs as required a State may elect to expend not less than 10 percent of such amount to support such programs by the end of two consecutive fiscal years.*

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-intervention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination, stabilization service to support reducing distress, promoting skill development and outcomes, manage costs, and better invest resources.

SAMHSA developed **Crisis Services: Meeting Needs, Saving Lives**, which includes "**National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit**" as well as an **Advisory: Peer Support Services in Crisis Care** and other related National Association of State Mental Health Programs Directors (NASMHPD) papers on crisis services. SAMHSA also developed "**National Guidelines for Child and Youth Behavioral Health Crisis Care**" which offers best practicies, implementation strategies, and practical guidance for the design and development of services that meet the needs of children, youth and their families experiencing a behavioral health crisis. Please note that this set aside funding is dedicated for the core set of crisis services as directed by Congress. Nothing precludes states from utilizing more than 5 percent of its MHBG funds for crisis services for individuals with serious mental illness or children with serious emotional disturbances. If states have other investments for crisis services, they are encouraged to coordinate those programs with programs supported by this new 5 percent set aside. This coordination will help ensure services for individuals are swiftly identified and are engaged in the core crisis care elements.

1. Briefly narrate your state's crisis system. For all regions/areas of your state, include a description of access to the crisis call centers, availability of mobile crisis and behavioral health first responder services, utilization of crsis receiving and stabilization centers.

   Washington's crisis system is operated at the regional level based on a framework overseen by HCA. HCA contracts with 10 regional Behavioral Health Administrative Organizations (BH-ASO). The BH-ASOs in each region contract with behavioral health agencies to operate mobile crisis, regional crisis lines, and crisis stabilization units. Washington passed a line tax 988 in 2021 and set out a plan to implement 988 and elements of SAMHSA's best practices. With the passage of this legislation planning work has been ongoing to implement a technology solution to coordinate the crisis system. The legislation also created the Crisis Response Improvement Strategy (CRIS) committee that has 36 members from diverse viewpoints to guide implementation of the crisis system improvements.

2. In accordance with the guidelines below, identify the stages where the existing/proposed system will fit in.

   *a) The **Exploration** stage: is the stage when states identify their communities' needs, assess organizational capacity, identify how crisis services meet community needs, and understand program requirements and adaptation.*
   *b) The **Installation** stage: occurs once the state comes up with a plan and the state begins making the changes necessary to implement the crisis services based on the SAMHSA guidance. This includes coordination, training and community outreach and education activities.*
   *c) **Initial Implementation** stage: occurs when the state has the three-core crisis services implemented and agencies begin to put into practice the SAMHSA*

guidelines.

*d) **Full Implementation** stage: occurs once staffing is complete, services are provided, and funding streams are in place.*

*e) **Program Sustainability** stage: occurs when full implementation has been achieved, and quality assurance mechanisms are in place to assess the effectiveness and quality of the crisis services.*

Other program implementation data that characterizes crisis services system development.

1. Someone to talk to: Crisis Call Capacity
- *a. Number of locally based crisis call Centers in state*
  - *i. In the 988 Suicide and Crisis lifeline network*
  - *ii. Not in the suicide lifeline network*
- *b. Number of Crisis Call Centers with follow up protocols in place*
- *c. Percent of 911 calls that are coded as BH related*

2. Someone to respond: Number of communities that have mobile behavioral health crisis mobile capacity (in comparison to the toal number of communities)
- *a. Independent of first responder structures (police, paramedic, fire)*
- *b. Integrated with first responder structures (police, paramedic, fire)*
- *c. Number that employs peers*

3. Safe place to go or to be:
- *a. Number of Emergency Departments*
- *b. Number of Emergency Departments that operate a specialized behavioral health component*
- *c. Number of Crisis Receiving and Stabilization Centers (short term, 23-hour units that can diagnose and stabilize individuals in crisis)*

a. Check one box for each row indicating state's stage of implementation

	Exploration Planning	Installation	Early Implementation Less than 25% of counties	Partial Implementation About 50% of counties	Majority Implementation At least 75% of counties	Program Sustainment
Someone to talk to	☐	☐	☐	☐	☐	☑
Someone to respond	☐	☐	☐	☐	☑	☐
Safe place to go or to be	☐	☐	☐	☐	☑	☐

b. Briefly explain your stages of implementation selections here.

Washington has fully implemented and staffed its 988 contact centers. We would have chosen fully implemented because there is still work to improve infrastructure and coordination, but that was not an option. We are still implementing new standards and expanding someone to respond category with plans to add more teams in the next few years as funding and workforce allow.
The "safe place to go or to be" is still under development. We are expanding facilities and implementing crisis relief centers with the passage of SB 5120 this year, but most are still under construction. For a "safe place to be" we are expanding the MRSS model in the state by implementing youth focused crisis response teams.

3. Based on SAMHSA's National Guidelines for Behavioral Health Crisis Care, explain how the state will develop the crisis system.

Washington State has passed comprehensive legislation in the past few years to implement SAMHSA's best practices in the state. Starting with HB 1477 passed in 2021 that implemented critical planning processes and infrastructure for future crisis contact hubs. Key components of this legislation include the creation of the Crisis Response Improvement Strategy committee that brings diverse views to make recommendations on how to implement changes to the crisis system. It also laid out criteria for a technology platform to be used by 988 hubs. It also created the first in the country requirements for fully funded commercial plans to make next day appointments available to their enrollees.

4. Briefly describe the proposed/planned activities utilizing the 5 percent set aside.

Washington will be substantially expanding mobile crisis outreach services including child/youth teams on a statewide basis. Recently passed legislation will improve availability of crisis relief centers, mobile crisis, and community-based crisis intervention services in the state with a goal of response times almost on par with other first responders. Block grant 5% set aside crisis funding will be used to augment the statewide crisis system, primarily distributed through our Behavioral Health Administrative Service Organizations (BH-ASOs) for use within their regions. Additionally, HCA will use some of the funding to provide state sponsored trainings for Designated Crisis Responders.

Please indicate areas of technical assistance needed related to this section.

We have provided an introductory training to mobile crisis providers across the state on harm reduction. We request technical assistance with identifying any available harm reduction trainings and materials, with a focus on behavioral health crisis intervention, that can be utilized to deepen the knowledge and skill set of our crisis system providers.

Please indicate areas of technical assistance needed related to this section.

We have provided an introductory training to mobile crisis providers across the state on harm reduction. We request technical assistance with identifying any available harm reduction trainings and materials, with a focus on behavioral health crisis intervention, that can be utilized to deepen the knowledge and skill set of our crisis system providers.

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Footnotes:

Environmental Factors and Plan

16. Recovery - Required

Narrative Question

Recovery supports and services are essential for providing and maintaining comprehensive, quality M/SUD care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders.

Recovery is supported through the key components of: health (access to quality health and M/SUD treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery- guided the approach to person-centered care that is inclusive of shared decision-making, culturally welcoming and sensitive to social determinants of health. The continuum of care for these conditions involves psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder, and services to reduce risk related to them. Because mental and substance use disorders can become chronic relapsing conditions, long term systems and services are necessary to facilitate the initiation, stabilization, and management recovery and personal success over the lifespan.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see **SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders.**

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the SAMHSA supported Technical Assistance and Training Centers in each region. SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

1. Does the state support recovery through any of the following:

   a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care? ◉ Yes ○ No

   b) Required peer accreditation or certification? ◉ Yes ○ No

   c) Use Block grant funding of recovery support services? ◉ Yes ○ No

   d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system? ◉ Yes ○ No

2. Does the state measure the impact of your consumer and recovery community outreach activity? ◉ Yes ○ No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

In 2015, Washington applied for a Centers for Medicaid/Medicare (CMS) 1115 Medicaid Transformation Project (MTP) waiver to provide supportive housing and supported employment services to individuals receiving Medicaid and who meet specific risk criteria. These services are collectively known as Foundational Community Supports. Individuals with SMI including youth 16 and up (with SED) are eligible for supported employment services. According to the Substance Abuse and Mental Health Services Administration's (SAMHSA) research, about 70 percent of adults with serious mental illnesses desire work. (Mueser et al., 2001; Roger et al., 2001). Supported Employment, also known as the Individual Placement and Support (IPS) model has been proven effective in at least 27 randomized, controlled trials. The 1115 MTP waiver provides supportive housing support services to assist individuals obtain and maintain housing using SAMHSA's evidence-based practice permanent supportive housing. Both Supportive Housing and Supported Employment Services are available to individuals with SMI and SUD conditions.

Since launching FCS in 2018, the program has enrolled nearly 20,000 unique individuals across Washington state. The program has launched numerous initiatives made possible through the use of Substance Abuse and Mental Health block grant funds to expand the reach of the program and the quality of these support services. To help ensure and improve upon the quality of FCS services, the state regularly incentivizes FCS providers to take part in the FCS fidelity reviews. These reviews embody a learning collaborative approach to improving the quality of supportive housing and supported employment services. SABG and MHBG funds have played a pivotal role in paying for agencies to send staff to participate on reviews, as well as host a baseline and follow-up review of their FCS services. These reviews present providers with the opportunity to learn and share best practices with other providers in the network.

To support FCS providers, the state has launched two rounds of grants to assist SUD treatment providers with the infrastructure necessary to join the FCS network and start supportive housing and/or supported employment services, which to date has brought in 17 new provider organizations with a focus on individuals with SUD. In early 2021, the state also began an interagency project that will see the creation of a virtual discharge planners toolkit aimed at connecting individuals exiting institutional settings to the various recovery support services available in Washington.

In late 2020, Washington received the authorization from CMS to expand FCS supportive housing services to Institution for Mental Disease (IMD) settings, in alignment with initiatives 4 and 5 of the MTP waiver. Historically, individuals with lengthy stays in IMD settings have been precluded from receiving FCS services due to Medicaid suspension and other challenges, which makes an individual ineligible from FCS. The state identified this as a gap in service coverage that might also prevent an FCS provider from working on a supportive housing plan with individuals in an IMD setting. However, as part of the COVID relief funds through SABG and MHBG, FCS will be able to reimburse supportive housing services to providers working with individuals as they transition from these settings to the community who lose their Medicaid eligibility.

The state received a one-year extension of the 1115 MTP waiver for calendar year 2022, which allowed the ability to continue services and make up for time lost due to addressing the COVID 19 pandemic. During this time, the state formally applied for a five -year renewal of MTP, which includes Foundational Community Supports as one of the initiatives continuing under the waiver. As part of the application, the state requested short-term rental assistance including one-time transition costs and six months' rent coverage for enrollees experiencing homelessness, who are at risk of homelessness, or transitioning out of institutional settings. Due to the application being submitted in July 2022, the state received a temporary 6-month extension of the waiver from January through June 2023.

In May of 2022, Washington started offering short-term rental assistance for Foundational Community Supports participants through its Transition Assistance Program (TAP). TAP is funded by state-only dollars and can pay for the short-term financial barriers to obtaining stable housing, including deposits, one-time fees, and first and last month's rent. The program also covers basic home goods and light furnishings. From launch to May 2023, TAP has served approximately 2,000 individuals.

In addition to the Foundational Community Supports, the Housing and Recovery through Peer Services (HARPS) is available to individuals with serious mental illness and co-occurring at risk of exiting to homelessness or at risk of entering inpatient behavioral health settings. HARPS provides participants with meaningful choice and control of housing and support services, using certified peer counselors who are trained as housing specialists. The HARPS project reduces homelessness and supports the

recovery and resiliency of individuals with serious mental illness, co-occurring mental health and substance use disorders. HARPS provides permanent supportive housing pre-tenancy and tenancy sustaining services to individuals. HARPS also includes a shallow bridge subsidy to assist with rent, deposits, application fees etc.

Peer Support services have been a Medicaid reimbursable service since 2005. Peer Support Services were added to the Substance Use Disorder State Plan in 2019 and we updated our eligibility criteria for people to become Certified Peer Counselors to include people whose lived experience was substance use only. Certified peer counselors provide recovery supports in a variety of behavioral health settings including but not limited to community behavioral health agencies, peer run agencies, homeless outreach programs, evaluation and treatment programs and hospitals. Peer services increase empowerment, champion hope, and promote the expectation that recovery is possible for everyone.

Washington's Peer Support program has trained and qualified mental health consumers as certified peer counselors since 2005. A "consumer" is someone who has applied for, is eligible for, or who has received mental health services. This also includes parents and legal guardians when they have a child under the age of 13, or a child 13 or older and they are involved in their treatment plan.

Washington’s Peer Bridger Program connects Certified Peer Counselors with people transitioning from inpatient settings to share a message of hope and recovery and help them ‘bridge’ from an inpatient setting to success in their community. Peer Bridgers provide peer support services to individuals in inpatient setting prior to discharge and after their return to their communities.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state. i.e., RCOs, RCCs, peer-run organizations

Since July 2019, SUD peer support services are a Medicaid reimbursable service. The Centers for Medicaid and Medicare approved Washington’s State Plan Amendment to include SUD peer services as a reimbursable service June 2019. Since 7/1/2019 when we started asking people to self-identify on the CPC application until present, we have had a total of 1367 who either identify as SUD or co-occurring apply to become a CPC. Many individuals had completed the Recovery Coach training and as much as we like the message and values this provides; it does not require that people self-identify. In order to meet CMS requirements, DBHR offered a ‘bridge’ training for individuals who have completed Recovery Coach training to become a CPC. DBHR has conducted 8 of those training events.

The Housing and Recovery through Peer Services (HARPS) program is available to individuals with a substance use disorder who are exiting or at risk of entering inpatient behavioral health programs and who do not have access to Medicaid. HARPS provides participants with meaningful choice and control of housing and support services, using peer housing specialists. The HARPS project reduces homelessness and supports the recovery and resiliency of individuals with substance use disorder. HARPS provides permanent supportive housing services to individuals at risk of entering or exiting inpatient behavioral health services. HARPS also includes a shallow bridge subsidy to assist with rent, deposits, application fees etc..

An Oxford House is a live-in residence for people in recovery from substance use disorders. An Oxford House describes a democratically self-governed and self-supported drug-free house. In Washington, HCA’s Division of Behavioral Health and Recovery (DBHR) is the state agency responsible for administering a revolving fund to initiate new Oxford Houses. Start-up house loans, for a maximum of $4,000 per house, are approved by Oxford House, Inc. and are paid back to DBHR’s revolving fund over a two-year period.? Washington boasts one of the largest numbers of Oxford Houses in the country with sites in 23 of the 39 counties within the state.
• As of April, 2023, we have 345 Oxford Houses and 3032 Beds available on a daily basis.
• Total Women’s Houses are 101 and 43 of those Houses are for Women with Children.
• Total of Men’s Houses are 244 and 24 of those Houses are for Men with Children.
• In the 345 Oxford Houses there are 276 houses and with 1,626 residents receiving Opioid Use Disorder Treatment.

In 2019, SHB1528 directed DBHR to create a Recovery Residence Registry based on the National Alliance for Recovery Residences. Recovery residences listed on the registry are verified by the Washington Alliance of Quality Recovery Residences (WAQRR) as following the National Alliance of Recovery Residences (NARR) best practices. These residences allow residents to use prescribed medication for physical health, mental health, and substance use disorders. An interactive map showing Oxford houses and Recovery Residences went live in early 2021. A revolving operating loan program using the Oxford model was also established and also went live.

As of May 2023, WAQRR has accredited an additional 35 homes for a total of 102 that have been approved to be on the HCA Recovery Residence Registry. There are currently 799 recovery residence beds in Washington state within these 102 accredited houses. WAQRR is in process of accrediting 64 additional homes that have submitted applications to be added to the HCA Recovery Residence Registry. WAQRR has scheduled training sessions toolkits to support community awareness and engagement and continues to provide technical assistance to new and established recovery residences to include in person and virtual training, webinars, and fidelity reviews.

In July of 2022, the HCA contracted with Pioneer Human Services to initiate an SUD Peer Bridger program. This program allowed for the hire of eight (8) additional Certified Peer Counselors to serve individuals transitioning from inpatient and/or residential settings to lower levels of care by providing peer supports, discharge planning, and goal setting during the transition process. To

date, this program has supported 154 individuals.

The coming years will see the facilitation of many changes to Peer Support Services due to the passing of ESSB 5555 in May 2023. This legislation promotes the professionalization of peer services by making a Certified Peer Specialist license under the Department of Health in Washington State. The HCA will facilitate the necessary changes which will include 80 hours of training and 1500 hours of supervision in direct services for full licensure. HCA will also contract for the development of a peer supervisor training and the creation of a database which will link Peer Specialists with employers looking to hire. Current Certified Peer Counselors will need an additional 40 hours of training in order to qualify for the Peer Specialist license and the HCA will facilitate the training coordination efforts for this purpose.

Announced in 2003 as a three-year initiative to help Americans suffering from substance abuse and addiction, the SAMHSA funded Access to Recovery (ATR) program was so successful, it continued to be funded through three additional cohorts. ATR is client-directed, offers choice, and measures outcomes such as criminal justice involvement, education and employment, stability in housing, social connectedness, and abstinence. Washington received all four cohorts and the last grant ended January 31, 2019. ATR is no longer to be funded by SAMHSA but many of the recovery support services implemented by the ATR initiative had been sustained through SABG or State Opiate Response Grant funds.

One of the other programs funded under the State Opiate Response Grant is our Peer Pathfinder Program. Using CPCs who identify as having lived SUD or co-occurring mental health and SUD are conducting homeless outreach and engagement to individuals with suspected Opiate Use Disorders (OUD) or stimulant disorders. Twenty-eight Peer Pathfinders have been hired and are working closely with DBHR's Projects for Assistance in Transition from Homelessness (PATH) teams. Peer Pathfinders are also developing relationships with local emergency rooms to engage individuals who present with OUD overdose symptoms.

5. Does the state have any activities that it would like to highlight?

DBHR has developed Recovery Support Service Fact sheets that provide education, information and resources to individuals to promote a self-directed life and help individuals live to the greatest extent possible and strive to reach their full potential.

- Housing and Recovery through Peer Services (HARPS)
- Oxford house fact sheet
- Peer bridger
- Peer pathfinder project
- Peer respites
- Peer support services
- Program to Assist in the Transition from Homelessness (PATH)
- Recovery residences
- Social determinants of health-housing
- Supported employment 1115
- Housing First
- Homeless Outreach Stabilization Transition (HOST) Project
- Clubhouse and Peer Run Organizations
- Supporting Recovery in Community

Please indicate areas of technical assistance needed related to this section.

Washington has proactively used SAMHSA sponsored policy academies to create strategic plans to improve housing and employment outcomes. DBHR would be interested in receiving technical assistance in developing a strategic plan to create an inventory of peer workforce needs and future opportunities to position CPC in various environments on the behavioral health services continuum. DBHR was fortunate to receive several Transformation Transition Initiative grants from NASHMPD – one specifically focused on creating a continuing education curriculum for peers working in crisis services. In conjunction with our four other continuing education curriculums (Peers providing supportive housing, peers providing supported employment, trauma informed approaches and working with individuals who have intersected with law enforcement) DBHR is interested in creating career pathways for peers.

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Footnotes:

Environmental Factors and Plan

17. Community Living and the Implementation of Olmstead - Requested

Narrative Question

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in **Olmstead v. L.C., 527 U.S. 581 (1999)**, provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of M/SUD on America's communities. Being an active member of a community is an important part of recovery for persons with M/SUD conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with M/SUD needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office for Civil Rights **(OCR)** cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

1. Does the state's Olmstead plan include:

Housing services provided	◯ Yes ◯ No
Home and community-based services	◯ Yes ◯ No
Peer support services	◯ Yes ◯ No
Employment services.	◯ Yes ◯ No

2. Does the state have a plan to transition individuals from hospital to community settings? ◯ Yes ◯ No

3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

Please indicate areas of technical assistance needed related to this section.

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Footnotes:

Environmental Factors and Plan

18. Children and Adolescents M/SUD Services –Required for MHBG, Requested for SUPTRS BG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SUPTRS BG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.[1]. Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.[2]. For youth between the ages of 10 and 14 and young adults between the ages of 25 and 34, suicide is the second leading cause of death and for youth and young adults between 15 and 24, the third leading cause of death.[3].

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.[4].

Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.[5].

According to data from the 2017 Report to Congress[6] on systems of care, services:

1. reach many children and youth typically underserved by the mental health system.
2. improve emotional and behavioral outcomes for children and youth.
3. enhance family outcomes, such as decreased caregiver stress.
4. decrease suicidal ideation and gestures.
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious M/SUD needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and

employment); and

- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

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[1]Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

[2]Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

[3]Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

[4]The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

[5]Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from **https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM**

[6] **http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf**

Please respond to the following items:

1. Does the state utilize a system of care approach to support:

a) The recovery of children and youth with SED? ◉ Yes ○ No

b) The resilience of children and youth with SED? ◉ Yes ○ No

c) The recovery of children and youth with SUD? ◉ Yes ○ No

d) The resilience of children and youth with SUD? ◉ Yes ○ No

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs:

a) Child welfare? ◉ Yes ○ No

b) Health care? ◉ Yes ○ No

c) Juvenile justice? ◉ Yes ○ No

d) Education? ◉ Yes ○ No

3. Does the state monitor its progress and effectiveness, around:

a) Service utilization? ◉ Yes ○ No

b) Costs? ◉ Yes ○ No

c) Outcomes for children and youth services? ◉ Yes ○ No

4. Does the state provide training in evidence-based:

a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families? ◉ Yes ○ No

b) Mental health treatment and recovery services for children/adolescents and their families? ◉ Yes ○ No

5. Does the state have plans for transitioning children and youth receiving services:

a) to the adult M/SUD system? ◉ Yes ○ No

b) for youth in foster care? ◉ Yes ○ No

c) Is the child serving system connected with the FEP and Clinical High Risk for Psychosis (CHRP) systems? ◉ Yes ○ No

d) Does the state have an established FEP program? ◉ Yes ○ No

Does the state have an established CHRP program? ○ Yes ◉ No

e) Is the state providing trauma informed care? ◉ Yes ○ No

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

The Family Youth System Partner Round Table (FYSPRT) provides leadership to influence the establishment and sustainability of Children's Behavioral Health principles statewide. The Statewide and Regional FYSPRTs play a critical role, within the Child, Youth and Family.

Behavioral Health Governance Structure, in informing and providing oversight for their communities and legislative-level policymaking, program planning, and decision-making.

Regional FYSPRTs serves as a mechanism for ensuring that local community input and the voice of families and youth with lived experience is present, participating in, and informing child, youth and family behavioral health. In alignment with the Children's Behavioral Health Principles, the Statewide and Regional FYSPRTs provide recommendations and strategies to improve behavioral health services, supports, and outcomes for children and youth and inform system transformation as well as review both process and outcome indicators including Wraparound with Intensive Services outcome and performance data. The FYSPRTs support System of Care values including:

1) Family and youth driven
2) Culturally and linguistically competent
3) Community-based

FYSPRTs also support the goals of the Washington State system of care:

1) Infuse system of care values in all child and youth serving systems.
2) Expand and sustain effective leadership roles for families, youth, and system partners.
3) Establish an appropriate array of services and resources statewide, including home-and community-based services.
4) Develop and strengthen a workforce that will operationalize system of care values.
5) Build a strong data management system to inform decision-making and track outcomes.
6) Develop sustainable financing and align funding to ensure services are seamless for children, youth, and families.

The state has established many protocols to ensure individualized care planning for children and youth with serious mental, substance use, and co-occurring disorders, including:

• Contracting with Managed Care Organizations to maximize resources, have mechanisms for broader care coordination, and ensure that individuals have options for access to quality services.
• Partnership with Managed Care Organizations and their care coordinators to ensure that the needs of youth in complex, cross system situations are supported.
• Continued work within Health Care Authority toward full purchasing integration with physical and behavioral health services.
• Statewide implementation of Wraparound with Intensive Services (WISe) emphasizes a wraparound approach for the youth with complex behavioral health needs. WISe requires a team approach which includes certified peer counselor and utilization of the Child and Adolescent Needs and Strengths (CANS) assessment tool to evaluate needs and strengths in multiple domains as well as monitoring outcomes at the individual, agency, regional and state level.
• Roll out of Washington State's First Episode Psychosis Initiative, New Journeys placing emphasis on early intervention services for individuals experiencing early onset symptoms of schizophrenia. Currently, 11 programs are operational with a goal of statewide by October 2023.
• Family Peer Partner and Youth Peer Partner development in services and system development.
• As a part of our Washington Administrative Code (WAC) 388-877-0620 Clinical – Individual Service Plan outlines components required for mental health and substance use disorder treatment; including, but not limited to:

• Address age, gender, cultural, strengths and/or disability issues identified by the individual or, if applicable, the individual's parent(s) or legal
representative.

• Use a terminology that is understandable to the individual and the individual's family.

• Demonstrate the individual's participation in the development of the plan.

• Document participation of family or significant others, if participation is requested by the individual and is clinically appropriate.

• Be strength-based.

• Contain measurable goals or objectives, or both.

The state has established collaborations with other child and youth serving agencies in the state to address behavioral health needs as evidenced by the coordinated contracts with Children's Long Term Inpatient Program (CLIP) and regional Behavioral Health Administrative Service Organizations (BH-ASOs). This effort has been strengthened by the System of Care Grant and T.R. Settlement driven Children's Behavioral Health Governance Structure including the Children's Behavioral Health Executive Leadership Team, the Statewide FYSPRT, and ten Regional FYSPRTs. The Statewide FYSPRT has a tribal representative and representatives from youth and young adult serving state partners: Department of Children, Youth and Families (DCYF), which now includes Juvenile Rehabilitation (JR) and the Department of Early Learning (DEL), Department of Health (DOH),), Department of Health and Human Services (DSHS), Office of Superintendent of Public Instruction (OSPI), Developmental Disabilities Administration (DDA), Commerce, and Managed Care Organizations

Block Grant Funding has been used for several years to provide 'no cost' training and follow-up coaching to clinicians in

Cognitive Behavioral Therapy Plus (CBT+). The dollars continue to support this work while in tandem developing a train-the-trainer model with the intention of placing local trainers in each Behavioral Health Organization to further grow the workforce."? Block grant also funds the Washington State Institute for Public Policy (WSIPP) to update its list of evidence and research-based practices (ERBP's) on its web site.

Contracted Managed Care Organizations (MCO's) for both integrated managed care and integrated foster care are required to promote the use of ERBP's to their contracted behavioral health agencies and report to HCA how they promote the use of ERBP's in a culturally competent manner.? Specific encounters of group, individual and family treatment sessions lasting more than 30 minutes have a code to indicate the use of an ERBP during that encounter.? MCO's are required by contract to report how they are providing training and technical assistance to BHA's in the reporting of those ERBP's for children/youth.

Monitoring and tracking service utilization, costs, and outcomes for children and youth with mental, substance use, and co-occurring disorders are performed through many different methods. These include:

• Tracking evidence-based practice (EBP) reporting, and multiple input methods for WISe and CANs progress tracking.

• Following through the payment system (Provider One).

• Using performance-based contracting and contract monitoring.

• Monitoring Children's Behavioral Health Measures.

Washington State has identified various liaisons to assist schools in assuring identified children are connected with available mental health and/or substance use treatment, and recovery support services. All these programs have been developed in coordination with the Washington State Office of Superintendent of Public Instruction (OSPI):

Mental Health Services
A program agreement was established to coordinate activities that promote cross-systems collaboration between local public mental health providers and local education agencies (LEAs) to provide services and programs for students who are eligible for special education services under the Individuals with Disabilities Education Act (IDEA) and who are eligible for services through the DBHR.

Prevention
Administered by the Washington State Office of Superintendent of Public Instruction (OSPI), federal Substance Abuse Prevention and Treatment block grant funds are awarded annually to regional Educational Service Districts. The Student Assistance Prevention Intervention Services program places Student Assistance Specialists in schools in Community Prevention and Wellness Initiative locations to address problems associated with substance use violence and other non-academic barriers to learning. Student Assistance Specialists (SAP) are assigned to designated school sites to provide direct services to students who are at risk and/or harmfully involved with alcohol, tobacco, and other drugs. SAP services include:

• Administer a uniform screening instrument to determine levels of substance use and mental health concerns.

• Individual and family counseling and interventions on student substance use.

• Peer support groups to address student and/or family substance use issues.

• Coordinate and make referrals to treatment and other social service providers; and,

• School-wide prevention activities that promote healthy messages and decrease substance use

7. Does the state have any activities related to this section that you would like to highlight?

(Please see above)

Please indicate areas of technical assistance needed related to this section.

None at this time.

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Footnotes:

Environmental Factors and Plan

19. Suicide Prevention - Required for MHBG

Narrative Question

Suicide is a major public health concern, it is a leading cause of death overall, with over 47,000 people dying by suicide in 2021 in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges M/SUD agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide using MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the M/SUD agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following:

1. Have you updated your state's suicide prevention plan in the last 2 years? ○ Yes ● No

2. Describe activities intended to reduce incidents of suicide in your state.

The State Strategic Prevention Enhancement Plan addresses suicide prevention and mental health promotion through the efforts of an interagency work group to address the goals set forth in the plan. In January 2016, Governor Inslee's Executive Order 16-02 on firearm fatality and suicide prevention, tasked several state agencies with addressing these issues.

Prevention Section:

Community-based organizations (CBOs) are state grant funded organizations that serve high-need communities by providing quality and culturally competent substance use disorder prevention and mental health promotion and suicide prevention programming through evidence-based, research-based, and innovative programs and strategies. CBOs can range from non-profits, faith-based organizations, educational service districts, schools, tribal or local governmental entities. CBOs are focused on the delivery of prevention and promotion programs and/or strategies to meet a targeted need. Such programs can include mentoring, parenting education, community awareness raising, training, and youth skill building.

CBOs and the programs they organize can support the larger?Community Prevention and Wellness Initiative (CPWI)?or other local or regional community coalitions of Washington State. Through partnerships like this, CBOs can help expand the reach of a coalition and build off their strategic plan. Alternately, CBOs can operate independently, providing targeted prevention and promotion programming to meet a need that organization has identified.
In January 2023, DBHR presented to the Governor for the Results WA Public Performance Review focus on suicide prevention. This presentation included information about the services and outcomes for the upstream suicide prevention efforts by HCA as well as our partner agencies Department of Health and Veteran's Affairs. Additional information and a video recording are available here: https://results.wa.gov/measuring-progress/public-performance-reviews.

3. Have you incorporated any strategies supportive of Zero Suicide? ● Yes ○ No

4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments? ○ Yes ● No

If yes, please describe how barriers are eliminated.

5. Have you begun any prioritized or statewide initiatives since the FFY 2022 - 2023 plan was submitted? ● Yes ○ No

If so, please describe the population of focus?

Adults over the age of 25, including victims of domestic violence. This grant was an 18-month grant and sunset in February of 2022.

Please indicate areas of technical assistance needed related to this section.

None at this time.

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Footnotes:

Environmental Factors and Plan

20. Support of State Partners - Required for MHBG

Narrative Question

The success of a state's MHBG and SUPTRS BG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The State Medicaid Authority agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations.
- The state's agency on aging which provides chronic disease self-management and social services critical for supporting recovery of older adults.
- The state's intellectual and developmental disabilities agency to ensure critical coordination for individuals with ID/DD and M/SUD conditions.
- Strong partnerships between SMHAs and SSAs and their counterparts in physical health, public health, and Medicaid, Medicare, state and area agencies on aging and educational authorities are essential for successful coordinated care initiatives. While the State Medicaid Authority (SMA) is often the lead on a variety of care coordination initiatives, SMHAs and SSAs are essential partners in designing, implementing, monitoring, and evaluating these efforts. SMHAs and SSAs are in the best position to offer state partners information regarding the most effective care coordination models, connect current providers that have effective models, and assist with training or retraining staff to provide care coordination across prevention, treatment, and recovery activities.
- SMHAs and SSAs can also assist the state partner agencies in messaging the importance of the various coordinated care initiatives and the system changes that may be needed for success with their integration efforts. The collaborations will be critical among M/SUD entities and comprehensive primary care provider organizations, such as maternal and child health clinics, community health centers, Ryan White HIV/AIDS CARE Act providers, and rural health organizations. SMHAs and SSAs can assist SMAs with identifying principles, safeguards, and enhancements that will ensure that this integration supports key recovery principles and activities such as person-centered planning and self-direction. Specialty, emergency and rehabilitative care services, and systems addressing chronic health conditions such as diabetes or heart disease, long-term or post-acute care, and hospital emergency department care will see numerous M/SUD issues among the persons served. SMHAs and SSAs should be collaborating to educate, consult, and serve patients, practitioners, and families seen in these systems. The full integration of community prevention activities is equally important. Other public health issues are impacted by M/SUD issues and vice versa. States should assure that the M/SUD system is actively engaged in these public health efforts.
- SAMHSA seeks to enhance the abilities of SMHAs and SSAs to be full partners in implementing and enforcing MHPAEA and delivery of health system improvement in their states. In many respects, successful implementation is dependent on leadership and collaboration among multiple stakeholders. The relationships among the SMHAs, SSAs, and the state Medicaid directors, state housing authorities, insurance commissioners, prevention agencies, child-serving agencies, education authorities, justice authorities, public health authorities, and HIT authorities are integral to the effective and efficient delivery of services. These collaborations will be particularly important in the areas of Medicaid, data and information management and technology, professional licensing and credentialing, consumer protection, and workforce development.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period? ◉ Yes ○ No
2. Has your state identified the need to develop new partnerships that you did not have in place? ◉ Yes ○ No

If yes, with whom?

We have strengthened our relationship with multiple courts across the state as part of continued outreach and engagement in the Trueblood phased regions to aid court partners in the most efficient ways to access outpatient forensic specialty services and outpatient competency restoration and will continue to provide assistance to additional court partners.

We continue to deepen relationships with our partners in education, justice, disabilities administration, early learning, and child welfare. We have supported cross agency connection, coordination, and specialty teams working on different aspects of the lifespan to increase coordination, understand needs and systems of our partners, and have moved toward piloting and establishing new work cross agency through state and federal dollars, including programs like Youth Behavioral Health Navigators. Additionally, we're focusing on our partnership with our juvenile justice system and access and supports through Wrap Around with Intensive Services to support re-entry. We partner with several layers of the educational system to increase access and to pilot access point to learn from and share such as the SAMHSA SOC grant funded Telehealth for schools playbook.

3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilities Education Act.

The Washington State Health Care Authority works with system partners to deliver services that promote successful transitions to and outcomes in community-based settings. Some examples are as follows:

• HCA contracts with managed care organizations to provide robust care coordination services to ensure clients are successful in community-based settings. MCO care coordinators are required to work closely with clients, providers, and other State agencies to support access to medically necessary state plan services, waiver-based habilitative supports, and state-only funded wrap around services to ensure best possible outcomes for managed care enrolled clients.
• Contractual requirements for MCOs and Behavioral Health Administrative Service Organizations require working as members of the state hospital Discharge Transition Team to identify potential discharge options and resolve barriers to discharge for assigned enrollees.
• Each of the BH-ASOs works with stakeholders across their region to ensure coordination of services and resources. BH-ASOs sponsor monthly/quarterly provider meetings. BH-ASOs and providers participate in community events, and coordinate with the schools to provide outreach and support access to services. The BH-ASOs work with other state agencies including Developmental Disabilities Administration (DDA), Division of Youth and Families, and Home and Aging and Long-Term Services Administration. BH -ASOs also participate in monthly coordination meetings the HCA and bi-monthly coordination meetings with the Managed Care Organizations.
• HCA contracts with community-based inpatient settings to provide behavioral health treatment for people on 90- or 180-day involuntary treatment orders. As part of these contracts, HCA expects the treatment settings to partner with the MCOs for Medicaid enrollees and BH-ASOs for people without Medicaid or outside of managed care, to assure complete discharge plans are in place for thoughtful transitions to lower levels of care.
• Multi-System Rounds is a weekly meeting that pulls together a comprehensive team of subject matter experts, state agency leaders and Managed care organization clinical staff to assist youth (<21) who are at risk for dependency, institutionalization, or experiencing complex barriers to accessing community-based care. Health Care Authority is working to expand this program to address the needs of other populations.
• Complex Discharge process reduces inpatient length of stay by ensuring MCOs are compliant with contract requirements for discharge planning and care coordination, identify and address barriers to discharge and implement solutions, with the goal of minimizing or eliminating discharge barriers. MCOs are required to submit weekly reports on care coordination activities for all clients in the state who are clinically cleared for discharge.
• Cross agency escalation pathways have been established to address cases where there are barriers to individuals being served successfully in community-based settings.
• Intensive residential treatment (IRT) teams work with individuals discharging or diverting from state hospitals or long-term hospitalizations who need wraparound support. The teams help those struggling to remain in community settings such as adult family homes (AFH) or assisted living facilities. IRT teams are the primary mental health provider and use elements from assertive community treatment (ACT) to provide intensive wraparound mental health care to the individual in their facility, helping them transition to a lower level of care.
• Legislatively funded Difficult to Discharge Task Force pilot program is under development.
• HCA participates in DSHS-led client Critical Case Protocol (CCCP) meetings as needed for clients at risk of losing their community-based residential providers due to illegal activity, high utilization of emergency/law enforcement services, housing issues, or increased support needs.
• HCA's School-Based Health Care Services (SBHS) program provides Medicaid reimbursement to schools for evaluations, reevaluations, and direct health related services provided by qualified staff that are included in an eligible student's IEP. Public schools are required per the Individuals with Disabilities Education Act to find and evaluate students who may have disabilities, at no cost to families. If a child has a qualifying disability, schools must offer special education and related services (like speech therapy and counseling) to meet the child's unique needs through an Individualized Education Program (IEP). Schools are not required to participate in the SBHS program; however, participation benefits the entire school population as it brings in additional funding which helps offset costs associated with providing these healthcare related services.
• We support coordination and connection with our state Office of Superintendent of Public Instruction (OSPI) and our Medicaid office. Current conversations are underway to explore the gap between IDEA serving through age 21 and Medicaid EPSDT through age 20. Our legislature is interested in ensuring those supports stay intact while students are in K-12 services.
• We also partner with our Medicaid office and OSPI to identify pathways to support schools seeking to support access for behavioral health for their students, and are exploring areas like peers in schools, and supports for schools to support teachers so they can support students.
• HCA also contracts with the child and youth Children's Longterm Inpatient Program (CLIP) that consists of community based Psychiatric Residential Treatment Facilities (PRTF) and the hospital-based Child Study Treatment Center (CSTC) to ensure supports and coordination both prior to admission and as part of discharge coordination to ensure supports for community-based supports and services for the child and family. Additionally, we contract with each program to ensure funding and support for familial/ natural support engagement during treatment in the CLIP program.

The Washington State Department of Social and Health Services works to support discharges to home and community, and delivers community based, person-centered services in community-based settings, including the following:

• Developmental Disabilities Administration:
• The Developmental Disabilities Administration (DDA) assists individuals with developmental disabilities and their families to obtain services and supports based on individual preference and capabilities and needs. DDA services help promote everyday activities, routines and relationships common to most citizens.
• Roads to Community Living is a demonstration project designed to help people with complex, long-term care needs move back into the community.
• Community Residential Services include both Alternative Living Services and Companion Home Services, which are provided in typical homes or apartments in the community.
• Home and community Services
• Home and Community Services (HCS) promotes, plans, develops and provides long-term care services for persons with disabilities and the elderly who may need state funds (Medicaid) to help pay for them.

Please indicate areas of technical assistance needed related to this section.

None at this time.

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Footnotes:

Environmental Factors and Plan

21. State Planning/Advisory Council and Input on the Mental Health/Substance use disorder Block Grant Application- Required for MHBG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in 42 U.S. C. 300x-3 for adults with SMI and children with SED. To meet the needs of states that are integrating services supported by MHBG and SUPTRS BG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as an Advisory/Planning Council (PC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a PC, SAMHSA has created **Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.**[1]

Planning Councils are required by statute to review state plans and implementation reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as an advocate for individuals with M/SUD problems. SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

[1] **https://www.samhsa.gov/grants/block-grants/resources [samhsa.gov]**

Please consider the following items as a guide when preparing the description of the state's system:

1. How was the Council involved in the development and review of the state plan and report? Attach supporting documentation (e.g. meeting minutes, letters of support, etc.)

The Behavioral Health Advisory Council (BHAC) was involved in the development and review of the state plan and report throughout the past year. To ensure ample time for thoughtful review and input, a copy of the FY2022-23 Block Grant application and priorities was submitted to BHAC for review in early December. The Block Grant Administrator then presented at the January meeting, reviewing in detail the Block Grant priorities and most recently reported outcomes submitted in the December 1st Block Grant Progress Report. The council formed workgroups to go over each priority before drafting final recommendations on the priorities they presented to DBHR leadership at the Advisory Council March meeting.

The Block Grant team, along with input from DBHR leadership, reviewed the feedback provided by BHAC and incorporated some of the recommendations, including but not limited to priority 13 workforce innovations, and adding a focus on DEI for peers in priority 4, adjusting into the workplan and priorities documents created for the FY2024-25 application.

At the July 2023 BHAC meeting, the Block Grant Administrator presented the draft priorities for the FY2024-25 Block Grant application. A second round of workgroups were formed by the council and compiled a final set of recommendations for the application that was sent to DBHR leadership in August 2023.

2. What mechanism does the state use to plan and implement community mental health treatment, substance misuse prevention, SUD treatment, and recovery support services?

Washington States planning council is integrated to address both mental health and substance misuse prevention, SUD treatment, and recovery services. The Behavioral Health Advisory Council sets aside multiple times on their yearly calendar to review and send recommendations to DBHR on the Block Grant application and its priorities. A Federal Block Grant Progress Report is presented at the January meeting. The Council then meets to identify needs and gaps in service and then sends written recommendations on the Federal Block Grant to DBHR at their March meeting. The Block Grant Administrator also presents a draft of the state's Block Grant priorities at the July meeting for the Council to review and comment on before the final application is submitted to SAMHSA.

Recommendations from the council, along with recommendations received by the Tribes during Tribal Listening Sessions, Roundtables and Tribal Councils, and recommendations received during the public comment period are taken into consideration for identifying needs and gaps in service for substance misuse prevention, treatment and recovery services.

3. Has the Council successfully integrated substance misuse prevention and SUD treatment and recovery or co-occurring disorder issues, concerns, and activities into its work? ◉ Yes ○ No

4. Is the membership representative of the service area population (e.g. ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)? ◉ Yes ○ No

5. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

The Behavioral Health Advisory Council (BHAC) was formed in 2012 and meets six times per year. Its membership is comprised of consumers and community members, including individuals with lived experience, family members or parents of children with SMI or SED, and Peer supports that represent the geographic and social diversity of the state with continued thoughtful recruitment efforts remaining under way to ensure representatives of tribal governments and other underrepresented communities are council seats reflective of the population served. The council also includes many partners and stakeholders from other state agencies including the Health Care Authority, Department of Corrections, Developmental Disabilities, Juvenile Rehabilitation, Department of Commerce-Housing, Department of Social and Health Services, the Office of the Superintendent of Public Instruction, as well as from regional Behavioral Health Organizations, Tribes, and providers. The Division of Behavioral Health and Recovery has utilized the collected group experience of the council to identify issues affecting service delivery and the impact of integration.

Please indicate areas of technical assistance needed related to this section.

We have reached out for technical assistance on yearly planning with our council in relation to the application.

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Footnotes:

Washington State Health Care Authority

Behavioral Health Advisory Council

January Agenda

Wednesday, January 4, 2023
9:30 AM– 12:15 PM

Attendees:					
☐	Keri Waterland	☒	Susan Kydd	☐	David Musser
☒	Michael Langer	☒	Richelle Madigan	☐	Michelle Burchett
☒	Teesha Kirschbaum	☒	Tana Russell	☒	Bridget Underdahl
☒	Michelle Tinkler	☒	Vanessa Lewis	☐	
☐	Jeff Spring	☒	Shawn Brannan	☒	DBHR Guest: Michael Brown
☒	Jenni Olmstead	☒	Clarissa Fletcher	☒	DBHR Guest: Kris Shera
☒	Jolie Ramsey	☐	Ruth Leonard	☒	Guest: Christal Eshelman
☒	Josh Wallace	☒	Janet Cornell	☒	Guest: Robert Hopkins
☒	Katie Mirkovich	☒	Nathan Lusk	☒	Guest: Carolyn Cox
☒	Nelson Rason	☒	Tori McDermott Hale	☒	Guest: Nanci Watson
☐	Kielan Lynch	☐	Kim Wright	☒	Guest: Mary O'Brian
☒	Marcia Mongain-Finkas	☐	Guest:	☐	Guest:

#	Agenda Items	Time	Lead	Decisions and Summary of Meeting
1.	Welcome & Call to Order • Attendance • Approve November minutes • Vote to approve new members Robert Hopkins and Christal Eshelman	9:30am	Josh Wallace, Richelle Madigan	Call to Order Approved November Minutes Council voted to approved Robert Hopkins and Christal Eshelman as members
2.	Council Member Roundtable BHAC council overview: • Increase advisory work and recommendations to DBHR • Increase general membership participation in this work • Strategic Plan •	9:45am	Roundtable	Susan Kydd- Has been doing research in trauma, looking to see how it impacts individuals with SUD and MH. Mary O'Brian- Yakima farmworkers client doing recruitment around workforce, were able to recruit more staff but continues to be a challenge. Richelle Madigan- Continuing advocacy for children youth and families. Tana Russell- Now have a new problem gambling prevalence study. Recently made a report to the state legislature. About to open foundations of gaming disorder to the public in the coming year. Bridget Underdahl- Project aware supervisor for OSPI. Continuing work with school districts and expanding to different ESD and providing Tier 3 services.

Michelle Tinkler- Doing 1st quarter report for OBHA and looking forward to the legislative session.

Vanessa Lewis- PAVE working with bullying and harassment and mental health services.

Shawn Brannan- No updates.

Jenni Olmsted- DCYF- No updates.

Clarissa Fletcher- Been working bringing resources to Juvenile Court with getting more PEER support through the TACID organization.

Jolie Ramsey- My update for the WA State Rehabilitation Council is that our next Council meeting will be February 9th and 10th. It will be a hybrid meeting. Also, we are focusing right now on exploring Rapid Engagement practices that could be used by DVR counselors. DVR is currently in order of selection, and getting potential customers some services and support while they are awaiting full services by DVR could help them get connected to supports, such as mental health services.

Josh Wallace- Moved OBHA out of Peer Workforce Development into its own division. Peer WA is working on DEI internally creating more opportunity for employee diversity, equity and sense of belonging to strength employee attraction and retention.

Katie Mirkovich- Updated customer services handbook for DBR. Revised online DBR training for staff and help provide more resources for clients.

Nelson Rascon- Just hired a new peer staff member for King County. Starting peer support services for incarcerated fathers when they get out.

Increase participation discussion-

Richelle Madigan- There is a need to increase the advisory work and participation of BHAC in support of DBHR.

Josh Wallace- Is there a time limitation on involvement or should there be more direction/ structure to increase involvement

Carolyn Cox- Is the website up to date/ is there current contact that we can point the public to?

			Richelle- A visibility subcommittee would be great to work on this but goes back to more participation of BHAC members to make this happen Marcia- Her barrier has been difficulty due to technology and living in rural community Tana- One barrier to responses/ involvement is that the BHAC scope is so broad, breaking down requirements and having specific asks to help create a more focused approach. Richelle- Creating a revolving calendar to help create a timeline of things that BHAC delivers to DBHR would help with this Susan- There are two big asks that BHAC needs to advise DBHR on. Advising DBHR on block grant recommendations and Peer Review. Suggested creating a Block Grant or recommendations committee to commit to this work Michelle Tinker- There is training available to help structure the council with this work. Michelle will compile what she thinks would be relevant to BHAC and report back. Nanci Watson- Look at the ratio of participants to reflect lived experience vs government/paid participants.
3. Short Break	10:20am	All	
4. Office of Behavioral Health Advocacy	10:35am	Michelle Tinkler	See PowerPoint
5. Directors Dialogue • Block grant progress report discussion • Legislative update/ Governor's Budget	11:00am	Michael Langer, Teesha Kirschbaum	**Janet Cornell BG Report-** Susan- How nimble can you be within moving funds around to meet priorities that were not met in the progress report. Janet- Looking at the gaps and building the reports 1) Priority #1 – Address high disproportionate rates of SUD and MH disorders and overdoses amongst AI/AN individuals in WA state a. Which tribes/tribal representatives have served as consultants in the writing of this priority area/goal/objectives? Priorities and goals are presented at Tribal Roundtables and Tribal Consultation annually for input/questions before the Block Grant application is finalized and submitted. b. Why were the target outcomes for first-year (3,400) and second-year (3,400) set at a lower threshold than the baseline (4,499)?

			The target goals were set lower due to Covid having an impact on treatment accessibility. 2) Priority #3 – Increase the number of youths receiving outpatient substance use disorder treatment a. The baseline in FY20 was 1695, why did it drop down to 711 in SFY21, and did not come back even to baseline in FY22 at 1624? Listed are impacts of COVID-19, schools as a referral source were also impacted, and BH workforce shortages, but was there something else that caused might have caused this drop? The main reason these numbers dropped so significantly was due to impacts of Covid and accessibility to treatment and referrals through schools dropping while in-person learning was limited/unavailable. – Increase the number of SUD certified Peers a. How was marketing done to find 430 peers who were interested in taking the peer training? i. We do not have a lack of people who are interested in the training, we continue to get around 100 applicants per month for the CPC training and our waitlist is coming down but still high. 1. We are contracting for 74 CPC trainings for FY23 and 65 CPC trainings were held in FY22, doubling our historical number of trainings per year. ii. We also contract for CPC Bridge trainings that certified Recovery Coaches to become CPCs iii. The Peer Support Program has implemented a Peer to Peer Newsletter and a monthly Peer Support Webinar "Peer Blend." iv. The Peer Support Program has a technical assistance program, Operationalizing Peer Support, that provides support and training to organizations who want to add peer services to their book of business or who need supports around their peer program. The training includes/but not limited to: building peer champions in your organization, supervision, and billing for peer support services. 1. Weekly "Office Hours" are provided to answer and provide supports to peer supervisors and program administrators. 2. Monthly webinars are held on different topics around implementing or supporting peer support programs v. Information on peer support to include job postings, continuing education training opportunities, upcoming webinars, and OPS Office Hours are sent out on the Office of Consumer Partnerships gov delivery vi. With one of the proviso's in the 2021/23 budget "Increase recruitment and retention of BIPOC Peers," HCA contracted with majority minority owned organizations to do the following:

1. Community outreach and oversee the application process for seed funding opportunities to promote the recruitment of BIPOC peer specialists
2. Seed funding advertisement and to create a report from information gathered from community listening sessions
3. Hold community listening sessions in marginalized communities to identify barriers and gaps to BH services with a focus on peer services
4. Hold BIPOC specific CPC trainings
5. Contract for 2 CPCs to be held in Department of Correction facilities (Walla Walla and Mission Creek)
6. Translation of standard CPC manual to Spanish
7. Hold CPC trainings in Spanish

b. Are there dates set yet for the Peer Pathways Annual Workforce Development Conference for 2023?
i. The conference will be held Wednesday 8/23 and Thursday 8/24
ii. Conference will either be held in King or Pierce County.

4) Priority #5 – Maintain outpatient mental health services for youth with SED
a. What factors contributed to the success of accomplishing this goal?
There are likely a broad array of nuances that led to this, the bigger items we believe impacted the outcome is continued expansion of New Journeys First episode Psychosis and Wrap Around with Intensive Services teams - along with the expansion of telehealth options.

5) Priority #7 – Maintain the number of adults with Serious Mental Illness (SMI) receiving mental health outpatient treatment services
a. Baseline was 192,662, goal was 104,128, actual was 216,740....why did the number of adults receiving OP MH services for SMI end up so high? Was there an increase in instances of SMI in the general population? Or improved access to care? Both? Something else? Will look into more detailed response

6) Priority #8 – Increase the number of individuals receiving recovery support services, including increasing supported employment and supported housing services for individuals with SMI, SED, and SUD
a. Indicator #1 - What factors contributed to the success of accomplishing this goal? Report mentions HCA worked with its provider network to increase referrals....how was this accomplished?
b. Indicator #2 – Baseline was 5,199, goal was 5,406, actual was 7,343...why so high? Did an increase in homelessness in general generate a larger population needing

			services, or was there improved access to services? Both? Something else? Report mentions an "increase in capacity of the provider network"...meaning more staff employed? Something else? Priority #9 – Increase the number of adults receiving outpatient substance use disorder treatment a. Baseline was 40,293 SFY20, goal was 47, 875, actual was over 4,000 less than the goal (est. 43,875, but actual number was not listed)....does this final number include individuals enrolled in tribal outpatient SUD tx programs? Yes, data pulled includes data reported into TARGET, which provides treatment data for Tribes. b. Report mentions an "unanticipated impact of fentanyl", what does that mean? What was that unanticipated impact, and how did that interfere with individuals seeking outpatient SUD tx? This was referring to unanticipated barriers that Fentanyl presents – treating someone for Fentanyl use is much different than treating for other opioids due to the half life of Fentanyl and the abundancy and potency. Additionally, with a higher mortality rate with Fentanyl the opportunity to get someone into treatment is reduced. 8) Priority #11 – Tuberculosis Screening a. If TB screenings and education in SUD outpatient and residential agencies was already required, then why is it listed here as a goal to continue that requirement? We are required to keep this as a priority within the Block Grant per SAMHSA Clarissa Fletcher- A lot of SUD providers are directly in the schools. What is being done working with law enforcement regarding reducing fentanyl overdoses? Michael Langer- DBHR is working with law enforcement but also working on communication campaigns, reducing barriers to treatment, and harm reduction. Focusing more on treating the SUD crisis as more of a healthcare problem than a criminal justice problem. Josh Wallace- there is work being done to introduce House bill 1006 to decriminalize the sale and purchase of schedule 1 testing strips which will help make it easier to provide fentanyl test strips. Tana Russell- Do you have employees from the OTP/MAT programs consulting on this goal? Michael- Yes its all hands on deck, we are working with them closely.

			Richelle- Are you looking at qualitative data in the BG report besides the quantitative data to get the full picture of services being provided. Janet- The progress report itself is pretty strict on how the report is complied and is heavy on the numbers/ quantitative data. Richelle- Somewhere In the process there should be a qualitative data where feedback can be provided. Janet- This is where we would love feedback from BHAC so that we can build to these goals. Michael- I'm not sure we need to keep the two connected where we have to report the quantitative data to SHAMSA as it pertains to the BG report. The qualitative part can be compiled in other ways. Richelle- If we're reporting to SAHMSA about the efficacy of BG programs there needs to be a qualitative part that shows the true efficacy of the services being provided. Janet- we do report on the qualitative portion of the report when we draft the application narrative around each of the priorities. Mike Brown responding to question regarding providers being delayed in getting their credentials for Medicaid. Mike Brown - Unfortunately, the workload continues to increase as the agency gets in compliance with credentialing requirements and getting folks trained to handle all application types can take a few months. We have been hiring and training for the last several months as well as authorizing overtime to work on the backlog. There are more issues on the horizon (PHE ending, NPI issue, LNI implementation) that will continue to put pressure on provider enrollment staff to keep up with the volume of incoming work. The delays are across all professions and provider application types. **Kris Shera- Opioid Settlement update** Kris Shera- There are many settlements out there but will focus primarily on the disturber settlement Will receive first amount 12/2022 and the second amount 7/2023 Recommendations for State ORP plan was submitted to Governor's office by 10/28/2022.

			State will not be able to use funds until 7/2023 once final budget approved and signed. Please set attached PowerPoint: Josh- Where is the settlement of the funding recovery support services. Feels there is a significant gap in recovery support services focuses only on housing and jobs. Kris- there were a lot of opportunities for input with workgroups submitting 3 proposals each. There will continue to be opportunities for more input as more settlements come in. Richelle- This conversation highlights the point that we're missing stuff where the rubber meets the road. Where we need to come up with a plan where the feedback that is provided is being implemented. we need to become a state that is proactive vs reactive. Michael- we haven't had a conversation yet fully. Kris did not have time to share the detail within each of the strategies presented. Most of the conversation we've had went into is how do we reduce barriers to support. Michael- There are more recovery support services in the plan that was submitted in the governor's budget. What's shown is the headline of each project. There are more services within them. Josh- Recovery support services are more than housing and jobs. Kris- This process is going to continue and get more resources as these settlements continue. We recognize that these funds do not meet the need that is out there. Kris offered to come to BHAC on a more regular basis. Josh- It is unfathomable to me that our State's authority on behavioral health and recovery could knowingly and intentionally exclude any funding for Recovery services in their recommendations to the Governor's office. Effective treatment of addiction disease requires every component identified by SAMHSA. Chronic disease does not manage itself. It must be provided for through long term care and

			support that is provided for under recovery support services. Governor's budget DP's Michael Langer- We sent out a draft on DPs for the governor's budget this morning. This is subject to change but it is an overview of DP's we sent to the governor. Richelle- Council will review the DP's sent out and send replies to Nathan and Michael.
6. Bylaw Changes: Formation of a bylaw committee to review and update bylaws Next steps, review action items, review March agenda items	12:00pm	Josh Wallace and Richelle Madigan	Bylaws Committee- Ask for Volunteers for Bylaw committee Christal Eshelman, Susan Kydd, volunteered. Email will be sent to request further volunteers. Agenda items for March, Action Items: submit formal recommendations for BG report Peer Review report and presentation Possible presentation from Kielan on Youth Buddies Request for members to please respond to the BG report if they haven't already. Nathan will compile questions and DBHR responses to executive committee
7. Adjourn	12:15pm	All	

Action Items/Decisions					
#	Action Item	Assigned To:	Date Assigned:	Date Due:	Status
1.					
2.					

Washington State Health Care Authority

Behavioral Health Advisory Council

March Agenda

Wednesday, March 1, 2023
9:30 AM– 2:00 PM

Attendees:					
☒	Keri Waterland (DBHR)	☒	Susan Kydd	☒	Christal Eshelman
☒	Michael Langer (DBHR)	☒	Richelle Madigan	☒	Bridget Underdahl
☒	Teesha Kirschbaum (DBHR)	☐	Tana Russell	☒	David Musser
☒	Robert Hopkins	☒	Vanessa Lewis	☐	Michelle Tinkler
☐	Jeff Spring	☒	Shawn Brannan	☐	Michelle Burchett
☒	Jenni Olmstead	☒	Clarissa Fletcher	☒	Guest: Carolyn Cox
☒	Jolie Ramsey	☐	Ruth Leonard	☒	Guest: Peggy Dolan
☒	Josh Wallace	☒	Nathan Lusk (DBHR)	☒	Guest: Tessa Clements
☒	Katie Mirkovich	☒	Janet Cornell (DBHR)	☒	Guest: Nanci Watson
☒	Nelson Rason	☒	Tori McDermott Hale DBHR)	☒	HCA Guest: Teresa Claycamp
☐	Kielan Lynch	☒	Kim Wright (DBHR)	☒	HCA Guest: Jessica Diaz
☒	Marcia Mongain-Finkas	☒	Grace Burkhart (DBHR)	☒	Dakota Steel (DBHR)

#	Agenda Items	Time	Lead	Decisions and Summary of Meeting
1.	Welcome & Call to Order • Attendance • Approve January minutes	9:30am	Josh Wallace, Richelle Madigan	Quorum Reached January minutes approved unanimously.
2.	Council Member Roundtable	9:45am	Roundtable	Nelson Rascon, member- Dad's Move, hired a new Peer Supervisor, still trying to hire 3 peers in King County, lots of trainings, hiring and looking to get credentialed to be able to give the MH Peer training. Susan Kydd, vice co-chair- Volunteer at Recovery Cafe, being trained as smart recovery trainer. Bridget Underdahl, member- Program lead for Project Aware, OSPI, has been able to expand into Spokane and Seattle, all their programs will be certified by mental health agencies. Robert Hopkins- No updates Katie Mirkovich, council secretary-, Supported Employment Program Manager, DSHS. DVR is a statewide resource assisting people with disabilities to prepare for, secure, maintain, advance in, or regain employment. DVR partners with organizations and businesses to develop employment opportunities. DVR serves people who seek meaningful, secure employment but whose disabilities may result in one or more barriers to achieving an employment goal. When DVR does not have adequate financial resources or staff capacity to serve all eligible individuals, it must establish a waiting list for services. Waiting list rules are established by

the federal Rehabilitation Services Administration (RSA) under a provision called "Order of Selection for Services" (34 CFR 361.36). These rules require that DVR serve individuals with most significant disabilities as a priority.
Services are initiated to individuals on the waiting list for services based on the date they applied for services with DVR.
As of February 1st, 2023, individuals in Priority Category 4 with application dates prior to September 28, 2018, have been released from the waiting list.
Priority Categories 1 (individuals with most significant disabilities), 2 (individuals with significant disabilities), and 3 (individuals with significant disabilities) will be open continuously (no waiting).
DVR reevaluates its service delivery capacity regularly to ensure it continues serving the greatest number of eligible individuals possible in the most effective manner.
While DVR remains under Order of Selection, individuals determined eligible in Priority Category 1, Priority Category 2 and Priority Category 3 continue to receive services.
Please feel free to reach out to me if you need assistance with general information about DVR or Find your local DVR office.
Marcia Mongain- Finkas- no updates

Shawn Brannon, member- no updates

Carolyn Cox, guest- getting ready for their 6th building bridges grant with OSPI. Able to bring the spark program into the Bremerton School district.

Christal Eshelman, member- Beacon Health is now Carelon Health. Just a name change, nothing is changing structurally.

David Musser, member- Things seem to be improving coming out of Covid. More services are getting provided in prison. Also, more peer services being offered.

Jenni Olmstead, member- No updates

Peggy Dolan, guest - following two bills- Family Care Act and Behavioral Health 360 that helps parents assess their children's mental health.

Jolie Ramsey, member- The WSRC just wrapped up their February quarterly meeting. Holding listening sessions in March with DVR field staff to see what they can do while prospective customers are on the waitlist.

Tessa Clements, guest - I am the Behavioral Health Program Lead for the Administrative Office of the Courts. We are working on many projects, at the moment but the most comprehensive project we have at the moment is providing The Sequential Intercept Model - Policy Research Associates (prainc.com) Facilitators training in May to state partners

				who are interested in becoming certified to help communities map the intercepts in their community and use it as a tool to start to fill gaps in the system. Clarissa Fletcher, member- No updates Richelle Madigan, council co-chair – No updates Josh Wallace, council co-chair- No updates
3.	Peer Review Presentation	10:10pm	Susan Kydd	See meeting attachment-2022 Peer Review Report Motion to approve draft. Peer Review approved unanimously.
4.	Short Break	10:40am	All	
5.	Federal Block Grant Progress Report Recommendations	10:50am	Executive Committee	See meeting attachment- 2023 Federal Bock Grant Recommendations Concern was raised, by guest, Peggy Dolane, that Priority 3 did not reflect the current law regarding age of consent. The council moved to amend Priority 3 wording to include complexity of youth consent and family involvement. Wording updated and approved unanimously. Motion to approve FBG recommendations. Recommendations approved unanimously.
6.	Directors Dialogue • Federal Block Grant Response to Recommendations	11:20am	Keri Waterland, Michael Langer, Teesha Kirschbaum	**Priority 1- Address high disproportionate rates of SUD and MH disorders and overdoses amongst AI/AN individuals in Washington State.** **Data and Reporting-** • Tribes are moving away from the old reporting system (TARGET) to a new system. No current timeline, there are two active pilot programs and work is ongoing at this point. **Workforce shortages related to AI/AN BH Services-** • Tribes did get part of the $100 million in SFY 2023 and will be included in the future if funds are available, some restriction with Block Grant funds. Some of these funds will address the workforce. There are also several tribal opiate summits happening this year, we can get those dates out to you. **Priority 3- “Increase the number of youths receiving outpatient substance use disorder treatment.”** **3. Improve BH youth services.**

A. Since block grant dollars are intended to support innovation, consider a funding proposal to create a youth inpatient environment that would be appealing to them.

- This is the developmentally specific focused work HCA is recommending when we review bills and look at new priorities.
- The block grant guidelines prohibit use for inpatient care.

B. Find a way to increase providers for youth SUD outpatient treatment, specifically:

1. **Perform behavioral health provider mapping of current adolescent services and networks. Identify access challenges and strategies to remove system barriers.**
2. **Use certified youth peer navigators to support current adolescent networks.**

Right now, we have CPC training, and you can break off into family/youth branch. Interested in hearing from youth peers if this is a training that works for them and what else can be done to support this work.

3. **Interface with the provider networks to increase the treatment initiation and engagement rates among the number of youths accessing SUD outpatient services.**

- Healthy Transitions Project grant was obtained specifically to address this need and increase access to developmentally specific treatment.
- HTP – innovative access point to help youth and adults who might otherwise not get connected to treatment get connected to treatment.
- HCA continues to look for additional grants and utilize current funding to develop and expand these services and appreciate this recommendation.
- Imagining SUD access report is key to this process to ensure youth have a voice in letting us know what services should look like.

Reimagining Access Report

- Reimagining Access was a five-month collaboration between the Washington State Health Care Authority (HCA) and Seattle-based co-design firm Do Big Good. Its purpose was to reimagine access to treatment for substance use disorders (SUD) and co-occurring disorders (COD) with

young people and their communities. Can send follow-up links to council.

- Reimagining Access - Final Report - Sept 18, 2022 (wa.gov)

FIT

Family initiated treatment (FIT) | Washington State Health Care Authority

FIT goals

The goals of FIT are to provide parents (as defined in **RCW 71.34.020**) a way to access services when they feel a youth may need behavioral health treatment (mental health or substance use), and for providers to engage youth in a manner that shows them the benefits of treatment so they are willing to provide their consent.

What FIT is:

A way for youth and/or their parents to seek out behavioral health treatment.

May be used to access medically necessary outpatient, inpatient, and residential services.

An opportunity for providers to meet youth where they are and to engage them in treatment.

Regular reviews are conducted for all youth in outpatient, inpatient, and residential services, to continually assess medical necessity.

What FIT is not:

FIT does not guarantee immediate access to behavioral health treatment services.

Services cannot continue beyond medical necessity.

FIT does not supersede federal substance use disorder laws.

Each provider's intake and assessment process may be different.

Priority 4- Increase the number of SUD Certified Peers-

DEI:

- HCA has funded 16 BIPOC specific training courses through proviso state funds in FY22 and 2 CPC Train the Trainers to increase the cadre of BIPOC CPC Trainers.
- HCA is in process of translating the CPC Standard manual into Spanish and then will hold CPC trainings in Spanish through proviso state funds.
- HCA provided 25 seed funding opportunities to organizations to increase recruitment of BIPOC peers through proviso state funds.
- HCA has 2 training courses scheduled within the Walla Walla State Penitentiary and Mission Creek Corrections center through proviso state funds.

Improve Peer Services:

- HCA provides travel support for 4 Standard Statewide CPC training courses per year with our limited FBG.
- We have continued to offer CPC training in a virtual format for peers who are unable to attend in person due to travel, employment, childcare, living in rural or frontier areas, or any other barriers.
- HCA has created several online continuing education opportunities over the past couple of years that are available free of charge to all CPCs.
  i. Enhancing your Cultural Intelligence
  ii. Intersection of BH and the Law
  iii. Documenting Peer Support
  iv. Ethics and Boundaries in Peer Support
  v. The Power of Peer Support in Crisis Settings
- HCA has created a 40 hour in person CPC Crisis training and needs additional funding to implement the training.

Increase peer services efficiencies and effectiveness:

- There has been a significant increase in the number of CPC training courses in the past couple of years. In FY23 we have 90 CPC trainings scheduled and have trained 786 CPCs in the first 8 months of FY23, over 400 of the peers certified identified as either SUD or COD.

- HCA has prioritized all applicants who need the training to maintain employment or who have a job offer to provide peer services in a Medicaid setting. We are able to keep up with the current demand for this group of applicants as well as applicants who are working in other BH settings. We have been able to do this with additional funding through COVID enhancement funds. Funds are expiring 3/14/2023.

- Current investment of $4.4 million in CPC.
- We do not do separate training courses for SUD or MH.
- Our standard training includes both SUD/MH – important to include both for peers.
- We train Recovery Coaches to become CPC through a shortened CPC training called “bridge” – all these would be SUD specific.
- Occasionally we may have SUD specific on-off training that occurs through outside organizations.

- Spending on SUD Peer Services.
  - FBG estimate $1,740,000 (including covid enhancement)

			○ General Fund State through the BIPOC recruitment proviso $380,000 • # of SUD Peers certified – approximately 400 since 7/1/2023 • 90 CPC training scheduled for FY23. • HCA does not have specific training for SUD Peer Support. ○ In 2019, HCA updated the manual to cover both MH and SUD. ○ In 2019 HCA created the "Bridge Training" to train Recovery Coaches to become CPCs through a shortened CPC training. ○ There has been one off training sponsored by outside organizations that have been SUD specific.
7. Lunch	12:00pm	All	
8. Directors Dialogue Continued • Legislative Update	12:15am	Keri Waterland, Michael Langer, Teesha Kirschbaum	FBG Responses continued **Priority 6- Increase capacity for early identification and intervention for individuals experiencing First Episode Psychosis.** **Relabel Priority** • FEP is services primarily for ages 16-25 but clinical discretion does allow for inclusion up to age 40, as evidence shows that some, especially women, present later. Because of this, youth would not necessarily be appropriate. Individuals is what is commonly used, would recommend leaving individuals or could consider emerging adults. **Priority 7- Maintain the number of adults with Serious Mental Illness (SMI) receiving mental health outpatient treatment services.** **Establish a new baseline.** • The goal was set lower than baseline because we anticipated seeing a drop in #'s served due to Covid impacts. Baselines and goals are adjusted with the full application every two years and will be adjusted this year. **Priority 8 - Increase the number of individuals receiving recovery support services, including increasing supported employment and supported housing for individuals with SMI, SED, and SUD.** **Expand Recovery Support Services**

- Asking for good things but the specific priority is revolving around housing and employment services - we need something specific and measurable. What else do they want to see funded?
- Suggested to create funding around ongoing support, possibly offering soft skills and hard skills around employment.

Priority #9 - Increase the number of adults receiving outpatient substance use disorder treatment.

Sublocade

- Sublocade is currently covered under Medicaid.
- Injectable Sublocade is expensive at about $1000 a shot so if FBG went to those not covered by Medicaid, question of funding amount and what to do if it ran out.
- Other cheaper forms of buprenorphine are also available.
- Also note that SAMHSA and DEA recently announced the elimination of the requirement for prescribers to have a DATA 2000 (X) waiver to prescribe buprenorphine.
- Effective immediately, all practitioners with a DEA registration that includes Schedule III authority can now prescribe medications for opioid use disorder as they would any other medication.

General Recommendations

Workforce Challenges

- We agree, this is important.
- There are limitations on what the block grant can fund that we must consider when allocating.
- **Current BG efforts?**
  - CPC trainings
  - CPC Crisis Trainings
  - Peer wellness coach trainings
  - WISe SED and ASD workforce development efforts
  - WAADAC workforce summit sponsorships
  - NAADAC indigenous workforce conference sponsorship

- **Startyourpath.org campaign**

For the reporting period 10/03-12/04:

  - 11,768,683 total impressions
  - 40,085 clicks
  - 23,072 landing page sessions (this is time spent, and action taken by a user)

			○ Amazon has seen a 101% increase in clicks. ○ Video continues to perform above our goal benchmarks a combine average viewer click through rate of 86% for English and 81% for Spanish. ○ Our Spanish version landing page sessions have increased by an average of 45% since last report. **Improve BH Services Measures of Success and Outcomes** • Any priorities added to the list need to be measurable. • Rural Services - 100m from leg is where a lot of the money is going to come from for these services. • DBHR continues to work to improve reporting requirements. • Is working to determine what needs to happen to produce outcomes survey's and get associated work into provider contract deliverables. • Creating more reports through an integrated database that follows through on longitude studies are not impossible. It would just take a lot of resources to do so. • We have spoken to some BHAC members about the idea of drafting a survey of why individuals don't engage in services. Maybe from folks that are incarcerated, in emergency rooms or in shelters and finding out, have you attempted to receive services, why did it not work or not work well for you? **Improve Efficiency of Reporting Requirements** • Agree, DBHR continues to adhere to federal requirements associated with these grants and communicate regularly with providers and our federal partners to provide TA to reduce barriers. **Harm Reduction** • Harm reduction is getting a lot of support. DBHR is currently following a lot of bills in the state legislature that address different areas of this, such as naloxone, syringe exchange, etc. • Also looking to lower barriers to harm reduction strategies and counseling. Did not get to Legislative update.
9. Behavioral Health Medicaid State Plan Amendment-	12:45pm	Teresa Claycamp, Jessica Diaz	See meeting attachment- Behavioral Health Medicaid State Plan Amendment Presentation
10. Short Break	1:30pm	All	

11. Vote to approve FBG Recommendations Vote to approve Peer Review Report Next steps, review action items, review May agenda items. Call for volunteers for • Membership Committee • Bylaw Committee	1:40 pm	Josh Wallace and Richelle Madigan	May Agenda: • Reach out to David Dickinson to go over SAMHSA and role BHAC in relation to Block Grant • Invite Peggy Dolan to present on FIT/ family rights. • DBHR response to BHAC Peer Review Call to Volunteers for Both Membership committee and Bylaw Committee. Nathan will follow up with an email.
12. Adjourn	2:00pm	All	

Action Items/Decisions

#	Action Item	Assigned To:	Date Assigned:	Date Due:	Status
1.	Call to Volunteers for Both Membership committee and Bylaw Committee. Nathan will follow up with an email.	Nathan	3/1/2023	?	
2.	Other outstanding action items here				

Washington State Health Care Authority

Behavioral Health Advisory Council

July Agenda

Wednesday, July 5th, 2023

9:30 AM– 1:15 PM

Attendees:					
☒	Keri Waterland (DBHR)	☒	Susan Kydd	☒	Christal Eshelman
☒	Michael Langer (DBHR)	☒	Richelle Madigan	☐	Bridget Underdahl
☐	Teesha Kirschbaum (DBHR)	☒	Tana Russell	☐	David Musser
☒	Robert Hopkins	☒	Vanessa Lewis	☒	Michelle Tinkler
☐	Jeff Spring	☐	Shawn Brannan	☐	Michelle Burchett
☒	Jenni Olmstead	☒	Clarissa Fletcher	☐	Tessa Clements
☐	Jolie Ramsey	☒	Ruth Leonard	☒	Guest: Nicole Mims (DBHR)
☒	Josh Wallace	☒	Nathan Lusk (DBHR)	☒	Guest: Michael Donovan (DBHR)
☒	Katie Mirkovich	☒	Janet Cornell (DBHR)	☒	Guest: Tom Kinlen (DSHS)
☒	Nelson Rason	☒	Tori McDermott Hale DBHR)	☒	Guest: Lisa LaRue
☐	Kielan Lynch	☒	Kim Wright (DBHR)	☒	Guest: Michael Donovan (DBHR)
☒	Marcia Mongain-Finkas	☒	Guest: Gabriel Hamilton	☒	Guest: Julee Christianson OSPI)
		☒	Guest: Teresa Claycamp DBHR)	☒	Guest: Miranda Meier (DBHR)

#	Agenda Items	Time	Lead	Decisions and Summary of Meeting
1.	Welcome & Call to Order • Attendance • Approve May minutes	9:30am	Josh Wallace, Richelle Madigan	Quorum Reached May Minutes approved
2.	Council Member Roundtable	9:45am	Roundtable	Robert Hopkins DCYF- Member • Will be attending the Northwest Opioid Summit Conference in Vancouver 7/19/23- 7/20/23 Julee Christianson- OSPI- Guest • Here representing the office of Superintendent of Public Instruction. New to her role supporting Project Aware school based mental health systems and supporting Bridget Underdahl, who I think you've met before. Thomas Kinlen- Director of the Office of Forensic Mental Health Services- Guest • Here to present on the Trueblood Presentation. Katie Mirkovich-DSHS- Division of Vocational Rehabilitation- Member • As of July 3, 2023, all individuals have been released from the DSHS Division of Vocational Rehabilitation (DVR) Order of Selection waiting list and all priority categories are open. • DVR will remain in an Order of Selection even though all priority categories are open to continue monitoring our

			capacity and resources to serve all eligible individuals in the state. DVR will still follow the same eligibility determination processes we currently have in place, and no changes are being made to our priority category definitions or the areas of functional limitation considered when determining priority of service. • While we remain in an Order of Selection, this change has positive impacts on those who need DVR services. We are aware that waiting lists have had negative impacts to our customers, and Order of Selection has been a challenge for staff, stakeholders, and the community we serve. DVR is thrilled to achieve this milestone! Michelle Tinkler- Office of Behavioral Health Advocacy- Member- • Finishing quarterly report • Hiring for a behavioral health advocate for both Pierce County and Great Rivers. Vanessa Lewis- PAVE- Member- • Her organization Fly Start is having an event 7/29/2023 sharing audio stories of those who are incarcerated and their experience of healthcare services, including mental health, while incarcerated. Will send out information. Josh Wallace- Peer Washington- Co-Chair- • Peer Washington launched their Peer network on both the East and West side of Washington. It is designed by peers across the state, providing support, resources, training, and employment opportunities. Richelle Madigan- Family Advocate- Co-Chair- • Started a job working for Washington State community connectors as a grant project manager, helping roll out the mobile response stabilization service. Susan Kydd- Community Advocate- • Mentioned the BHAC meeting with the SAMHSA monitoring visit last week. Would like BHAC to be more involved in actually reviewing the BG application. Clarissa Fletcher- Pierce County Juvenile Court- member • Also a member of Black Tacoma Black Collective. One thing they are working on is how to train black barbers in first aid mental health since there is a stigma of mental health among black men. Will send out additional information to the council.
3. Short Break	10:55	All	

#	Item	Time	Presenter	Notes
4.	Trueblood Presentation	10:15pm	Nicole Mims, Michael Donovan, Tom Kinlen	See presentation material: 05-2023 Trueblood Implementation Status
5.	Short Break	10:50am	All	
6.	Directors Dialogue • Special Session/ Budget Update	11:00am	Keri Waterland, Michael Langer, Teesha Kirschbaum	Michael Langer – Deputy Director DBHR- • Upcoming conferences we will send out to you. In July and August: Please see: HCA-DBHR Annual Conference Information • Contracts- Working to get contracts out, Some contracts will also come out of competitive procurement. Can take 3-6 months. Anticipating 15-20 new procurements. • Looking forward to the next session and what we may be requesting regarding agency request legislation. Keri Waterland- Director- DBHR- • Agency Request legislation- have two high level agency legislation requests we would like to discuss. • 2988- bill to expand the liability protections for workers working in mobile crisis response. Essentially a Good Samaritan sort of protections where if the worker is responding within the scope of their employment • 7105 - involuntary treatment act, as many of you know, allows for the detainment and the individuals who may not have a primary mental health or behavioral health diagnosis, specifically a primary diagnosis of some sort of neurocognitive traumatic brain injury. Looking into if it could be opened up so that an individual could be detained as a result of a neurocognitive condition as opposed to a behavioral health condition. • Appreciation to the planning council and the block grant team for participating in the SAMHSA monitoring visit last week. Want to acknowledge that we hear the desire for more time with the application and priorities for the block grants. Introduced Teresa Claycamp • Returned to DBHR as our Behavioral Health Strategic Advisor and working with us on high level behavioral health.

				Susan Kydd- We would like to form workgroups in August similar to what we did at the beginning of the year with the Block Grant Priorities. Michael Langer- Shared is experience at the national NASDAD conference he attended in DC. • national trends including the low levels of men entering the behavioral health field and how we can increase that. • how we can elevate as a country appreciation and recognize behavioral health workers as we do for first responders and veterans. Susan Kydd- Read that Washing state now have the highest overdose death rate in the country. Michael Langer- • Yes we know it's a wave, so there are states in the Midwest and East that are starting to come down as the West Coast is escalating. • Are trying to flood the community with naloxone and try to make it as easy as possible to prescribe the medication needed. • Also building out the Recovery Navigator program and do more outreach in the community. • If the Council has any ideas on how we can do more, please reach out Richelle Madigan- there's a need of finding a way to incorporate youth in overdose education. Tana Russell - Is Naloxone available at community colleges and colleges in the state? Michael Langer - I know that high schools are required to provide Naloxone when they reach a certain size.
7.	Lunch	12:00pm	All	
8.	• Final Draft of Block Grant Priorities	12:15pm	Janet Cornell	See presentation materials.
9.	Next steps, review action items, review September agenda items.	1:00pm	Josh Wallace and Richelle Madigan	Set up a meeting in the coming weeks to walk through block grant application. Nathan to send out invite to teams. Will use same teams as they did in March. Nathan to send out SharePoint meeting invite to go over training/access for BHAC members. September Agenda:

			Process improvement for the BG application Request for Mobile Response team to present. BHAC Strategic planning
10. Adjourn	1:15pm	All	

Action Items/Decisions					
#	**Action Item**	**Assigned To:**	**Date Assigned:**	**Date Due:**	**Status**
1.	Send out Vanessa Lewis and Clarissa Fletchers Round Table information.				
2.	Send upcoming conferences that are happening throughout the state.				
3.	Nathan to work and schedule with the Council to form workgroups for block grant application responses. (August) Sent out August 1, with responses from BHAC due 8/11/23				

BHAC Recommendations for MH and SUD Federal Block Grant Priorities
February 9, 2023

Priority 1- Address high disproportionate rates of SUD and MH disorders and overdoses amongst AI/AN individuals in Washington State.

1. **Data/Reporting**
   Discussion
   The Annual Update Report stated that HCA has no technical assistance to support Tribes to enter data into the data system. There is also a concern that individuals are being counted multiple times each time they enter treatment and inflating numbers.
   Recommendation:
   Determine whether tribal government would like technical assistance in data collection, and if so, provide it.
2. **Workforce shortages related to AI/AN BH Services**
   Recommendation:
   Provide direct allocation of funds through government-to-government processes for tribes working with AI/AN individuals that have SUD and MH disorder to address workforce shortage such as hiring bonuses, etc., and ongoing staff BH/SUD professional training opportunities focused on SUD and MH disorders and the disproportionate rates of AI/AN overdoses.

Priority 3- "Increase the number of youths receiving outpatient substance use disorder treatment."

3. **Improve BH youth services.**
   Discussion: Currently it is difficult to find outpatient treatment for youth even when court ordered. Also, there are only two providers in the state for youth withdrawal management.
   We know intrinsic motivation works over all others, the complexity of youth consent requires creating a treatment environment that feels safe and appealing to youth and proactively engages family involvement. This would increase the number of those seeking treatment as well as improve effectiveness.
   Recommendations:
   A. Since block grant dollars are intended to support innovation, consider a funding proposal to create a youth inpatient environment that would be appealing to them.
   B. Find a way to increase providers for youth SUD outpatient treatment, specifically:
      1. Perform behavioral health provider mapping of current adolescent services and networks. Identify access challenges and strategies to remove system barriers.
      2. Use certified youth peer navigators to support current adolescent networks
      3. Interface with the provider networks to increase the treatment initiation and engagement rates among the number of youths accessing SUD outpatient services.

Priority 4- Increase the number of SUD Certified Peers

4. **Recommendations:**
   A. **DEI:** This goal could be more impactful if it was built out so that it is not only "increase SUD certified Peers" but increase DEI and other markers of diversity among those accepted to training such as BIPOC, LGB+, transgender, gender non-conforming, refugees, different languages, rural, etc.
   B. **Improve Peer Services**: Use FBG funds to improve certified peer services the same way we support community health workers. Specifically, access to training (travel, lodging etc.) and/or provide trainings in rural areas by providing ample support, access to continuing education, etc.
   C. **Increase peer services efficiencies and effectiveness**: Partner with DOH to reduce the amount of time to receive the AAC for peers. Several programs this year specifically provided funding to support

peers (which is great) but the programs were very slow to launch due to delays in being able to take the CPC course and receive their AAC. This also caused peers some concern over their employment continuing as they were employed but unable to fully contribute to the team.

Priority 6- Increase capacity for early identification and intervention for individuals experiencing First Episode Psychosis.

5. **Recommendation: Relabel Priority**
   If the primary goal is to increase community based behavioral health services to transition age youth who are diagnosed with First Episode Psychosis (FEP), It should be relabeled as youth instead of individuals.

Priority 7- Maintain the number of adults with Serious Mental Illness (SMI) receiving mental health outpatient treatment services.

6. **Discussion - Improve Target Measurement**
   The baseline for this target was 192,662. The goal was 104,128 and the actual was 216,740. The number of adults receiving OP MH services for SMI ended up so high because the increase was in numbers served. This does not appear to be an effective baseline.
   Recommendation - Establish a new baseline.

Priority 8 - Increase the number of individuals receiving recovery support services, including increasing supported employment and supported housing for individuals with SMI, SED, and SUD.

7. **Discussion – Expand Recovery Support Services**
   DBHR's support of recovery support services are too narrowly focused on housing and employment. It has become apparent that the most important ingredient of recovery is connection and community. In our experience, housing and employment is sufficient for sustained recovery for some, but many individuals need to have ongoing access to the recovery support services specific to their needs and the tools to find and keep employment and housing while staying in recovery.
   Recommendations:
   A. Invest in establishing additional Recovery Community Organizations.
   B. Provide more funding for support services for those who have returned to work or been placed in housing to ease them into the stresses of these life changes until they become the norm for them.
   C. Decrease the significant supportive housing wait times by better coordination amongst the many different agencies involved, with the goal of efficiently utilizing braided funding.

Priority #9 - Increase the number of adults receiving outpatient substance use disorder treatment.

8. **Discussion - Sublocade**
   DBHR's Annual FBG Update Report mentioned that a contributing factor in the failure to meet this priority is the effects of fentanyl use. Because fentanyl is approximately 50 times more potent than heroin, withdrawal symptoms are extremely severe and are a barrier to entering any kind of treatment without medically assisted treatment.
   Also, the efficacy of medicines used for medically assisted opiate use disorder treatment vary widely because of the risks of diversion and the short-term effects of many of them. However, recent studies show extended-release buprenorphine (Sublocade) has been very effective in addressing these risks. This is a 30-day injectable medicine.
   Recommendation: Increase the amount of Sublocade available for withdrawal management. If interested, attached a presentation by Dr. John J. Mariani titled "Extended-Release Buprenorphine in the Fentanyl Era". Dr Mariani is the premier researcher in the US on Sublocade and provides advice for clinicians. Another resource is Dr. Catherine Smith, who has successfully implemented a Sublocade

program in Washington State's DOC has graciously agreed to be a resource if needed. We will provide contact information upon DBHR request.

General Recommendations

Workforce Challenges

9. **Discussion -** An overarching theme throughout the report is the constraints placed on the system by limited and burnt out workforce. Without addressing the root causes of workforce shortages in the behavioral health field, meeting targets will continue to be a challenge. For example, funding hiring bonuses is great for attracting staff, but does nothing for building the workforce if it only serves to pull people from other agencies. This results in maintaining low numbers of workforce while creating more stress on the system that is typical with losing staff at locations where the existing staff have to leave to access such a benefit.

   Recommendations:

   A. Workforce innovation - Support innovation to increase direct number of service providers at all levels.

   B. Prioritize Workforce Shortages in FBG Priorities - Create workforce shortages as a stand-alone priority within FBG report (since it is an identified barrier in many of the existing priorities).

   C. Rural Services - Find a way to increase the Behavioral Health infrastructure and increase # of providers to rural/ underserved areas.

   D. Compensation: Find a way to increase funding to providers so they are paid fairly based on their education/skill level.

Improve BH Services Measures of Success and Outcomes

10. **Discussion -** Currently FBG targets do not reflect the outcome or success of services provided because they do not reflect any improvements in the clients behavioral health status. Targets are generally process measures rather than outcome measures.

    A. **Recommendation** Would be ideal to have a mix of process measures and outcome measure to understand are we actually having the impact intended, such as all the social determinates of health (not just housing and employment).

    B. **Recommendation** Create a way to follow up with clients/patients 3 months, 6 months, year after services provided to see what impact program has on them.

    C. **Recommendation** Create a satisfaction survey BH providers must provide to patient/clients to collect qualitative data of services provided, so that this information may be used to identify and remove barriers. There is an existing BH Enrollee Survey that is reported on annually. If the timing aligns with FBG reporting, we could use this data. Otherwise, create a separate survey, and include the data from this survey in FBG report.

    D. **Recommendation** Collect data within hospitals/penal systems to see if hospitalized and/or incarcerated people with BH concerns tried to access other BH services prior to their admit/incarceration, if not, why? And if so, why those services did not meet the need.

Improve Efficiency of Reporting Requirements

11. **Recommendation**: Streamline/ease cumbersome reporting requirements for providers receiving BG funds so that this is no longer a barrier to timely services.

Harm Reduction

12. **Recommendation** - Increase funding for harm reduction supplies, including specifically fentanyl test strips and other drug checking/testing tools (e.g. benzodiazepine test strips).

SAMHSA Mental Health (MHBG) and Substance Use Prevention Treatment and Recovery Services (SUPTRS) Block Grant FFY 2024 – 2025 Application Review Behavioral Health Advisory Council

Division of Behavioral Health and Recovery

Washington State Health Care Authority

Agenda

- Brief Overview of Biennial Plan Update and Purpose
- Review of FY24 Priorities

Background Information on the SAMHSA Mental Health (MHBG) and Substance Use Prevention Treatment and Recovery Services (SUPTRS) Block Grant Application

Block Grant Biennial Application and Timeline

The Block Grant biennial application prioritizes federal funding to address SUD and MH needs within Washington.

FY22-23 Priorities sent to BHAC for review: December 12, 2022

Review of FY22-23 Priorities with BHAC: January 4, 2023

BHAC recommendations on Priorities provided to HCA: March 1, 2023

HCA begins work on application: March 1, 2023

SAMHSA opens application and provides instructions on requirements: July 1, 2023

Revisions begin for new application requirements provided by SAMHSA: July 1, 2023

Review of FY24-25 Priorities with BHAC: July 5, 2023

Tribal Roundtables: July 12 & July 26, Tribal Consultation: August 8, 2023

Public Comment period tentatively scheduled:

August 18 – 25

Biennial application is due to SAMHSA: September 1, 2023.

MHBG and SUPTRS Purpose

- To support needs across a continuum of care, consistent with SAMHSA vision for a high-quality, self-directed, and satisfying life.
- Substance Use Prevention, Treatment and Recovery Services Block Grant (SUPTRS)
  - Formerly known as SABG, renamed in 2022.
  - Provides states with the flexibility to design and implement activities and services to address the prevention of SUD and the complex needs of those impacted by substance use disorders
- Mental Health Block Grant (MHBG)
  - Provides treatment and recovery services for adults with Serious Mental Illness (SMI) and children with Serious Emotional Disturbance (SED)

Substance Use Prevention, Treatment & Recovery Services Block Grant Requirements

- SAMHSA directs that Substance Use Prevention, Treatment, and Recovery Services Block Grant be used to:
  - Plan, implement, and evaluate activities that prevent, treat and provide recovery support services for substance abuse using the SUPTRS block grant.
  - Collect performance and outcome data to determine the ongoing effectiveness of SUD prevention, treatment, and intervention, and recovery supports.
- Set aside requirements:
  - 20% of SUPTRS funds must be used for primary prevention strategies
  - Targeted populations include pregnant parenting people and people with dependent children (PPW) and persons addicted to the use of intravenous drugs (IVD)

Mental Health Block Grant Requirements

- SAMHSA directs that the Mental Health Block Grant be used to:
  - Serve adults diagnosed with a Serious Mental Illness (SMI) or youth with Serious Emotional Disturbance (SED) through MHBG
- Set aside requirements
  - 10% First Episode Psychosis
  - 5% Crisis Services

Review of 2024 SUPTRS and MHBG Priorities

Washington State
Health Care Authority

Priority 1

- Address high disproportionate rates of SUD and MH disorders and overdoses among American Indian and Alaska Native Individuals in WA State.
- Baseline:
  - SUD Treatment – Individuals served 3,355.
  - SUD Prevention – Average of 51,714 total unduplicated participants served by direct tribal prevention services provided during SFY22 (July 1, 2021- June 30, 2022)
- Target/Outcome:
  - First-Year Target –
    - SUD Treatment - Individuals Served 3,355
    - SUD Prevention – Increase or maintain 51,714 total unduplicated and duplicated participants in direct services prevention programs.
  - Second-Year Target –
    - SUD Treatment - Individuals Served 3,355
    - SUD Prevention – Increase or maintain 51,714 total unduplicated and duplicated participants in direct services prevention programs.

Priority 2

- Reduce Underage and Young Adult Substance Use/Misuse
- Baseline: Average of 12,217 unduplicated participants served by direct services provided between SFY 2020-2022 (July 1, 2020 – June 30, 2022)
- Target/Outcome:
  - First-year Target: Maintain a minimum of 12,217 unduplicated participants in direct service prevention programs.
  - Second-year Target: Maintain a minimum of 12,217 unduplicated participants in direct service prevention programs.

Priority 3

- Increase the number of youths receiving outpatient substance use disorder treatment
- Baseline: SFY22 (July 1, 2021 – June 30, 2022): 1,690 youth received SUD outpatient treatment services
- Target/Outcome: SFY22 (July 1, 2021– June 30, 2022): 1,690 youths received SUD outpatient treatment services.
  - First-year Target: Increase the number of youths receiving SUD outpatient treatment services in SFY24 to 1,900
  - Second-year Target: Maintain the number of youths receiving SUD outpatient treatment services in SFY25 to 1,900

Priority 4

- Increase the number of SUD Certified Peers
- Baseline: Target/Outcome: From July 1, 2021– June 30, 2022 total number of SUD trained peers was 488
  - First-year Target: Peer support program in SFY24 that would train 420 peers (total of 900 peers trained overall)
  - Second-year Target: Peer support program in SFY25 that would train 480 peers (total of 960 peers trained overall)
- New strategies added per recommendations of the Behavioral Health Advisory Council:
  - Focus on diversity, equity and inclusion practices to improve diverse peer services in underserved communities.
  - Increase recruitment of BIPOC Certified Peer Counselors and increase diversity of training organizations and CPC trainers.

Priority 5

- Maintain outpatient mental health services for youth with SED
- Baseline: SFY22: 76,941 youth with SED received services.
- Target/Outcome:
  - First-year Target: Maintain the number of youths with SED receiving outpatient services to at least 76,941 in SFY24
  - Second-year Target: Maintain the number of youths with SED receiving outpatient services to at least 76,941 in SFY25

Priority 6

- Increase capacity for early identification and intervention for individuals experiencing First Episode Psychosis (FEP)
- Baseline: SFY22: 12 First Episode Psychosis programs serving a total of 308 youth.
- Target/Outcome:
  - First-year Target : FY24 (July 1, 2023 – June 30, 2024) Increase the number of coordinated specialty care sites to 17 serving a total of 375 youth statewide.
  - Second-year Target: FY25 (July 1, 2024 – June 30, 2025) Maintain the 17 coordinate specialty care sites and begin implementation of adding up to three additional sites with a total of 400 youth served statewide.

Priority 7

- Maintain the number of adults with Serious Mental Illness (SMI) receiving mental health outpatient treatment services
- Baseline: SFY22: 216,740 adults with SMI received mental health outpatient services.
- Target/Outcome:
  - First-year Target : Maintain a minimum of 195,046 adults with SMI receiving mental health outpatient services in SFY24 (we anticipate a decrease in numbers, bringing us closer to our normal baseline pre-Covid)
  - Second-year Target: Maintain a minimum of 195,046 adults with SMI receiving mental health outpatient services in SFY25 (we anticipate a decrease in numbers, bringing us closer to our normal baseline pre-Covid)

Priority 8: Indicator 1 Supported Employment

- Increase the number of individuals receiving supported employment services for individuals with SMI, SED and SUD.
- Baseline: FY22 – 4,614 enrollments in supported employment.
- Target/Outcome:
  - First-year: Increase the number of people receiving supported employment services per month (over a 12-month period) by 4% in FY24 (total 4,798 enrollments)
  - Second-year: Increase the n number of people receiving supported employment services per month (over a 12-month period) by 4% in FY25 (total 4,989 enrollments)

Priority 8: Indicator 2 Supported Housing

- Increase the number of individuals receiving supported housing services for individuals with SMI, SED, and SUD
- Baseline Target/Outcome: FY22: 7,353 enrollments in supportive housing
  - First-year Target: Increase the average number of people receiving supporting housing services per month (over a 12-month period) by 4% in FY24 (total of 7,647 enrollments)
  - Second-year Target: Increase the average number of people receiving supporting housing services per month (over a 12-month period) by 4% in FY25 (total of 7,952 enrollments)

Priority 9

- Increase the number of adults receiving outpatient substance use disorder treatment, including those prescribed medications for opioid use disorder
- Baseline: SFY22: 41,825;
  - SFY2020 Precent of Medicaid enrollees with OUD accessing Medications for Opioid Use Disorder: All MOUD 39.2%, Buprenorphine/Bup-Naloxone 24.5%, Methadone 14.3%, Naltrexone 1.5%.
- Target/Outcome:
  - First-year Target: Increase the number of adults with SUD receiving treatment in SFY24 to 47,875. Percent of Medicaid enrollees with OUD accessing Medications for Opioid Use Disorder: All MOUD 45%, Buprenorphine/Bup-Naloxone 27%, Methadone 16%, Naltrexone 2%
  - Second-year Target: Increase the number of adults with SUD receiving treatment in SFY25 to 48,888. Percent of Medicaid enrollees with OUD accessing Medications for Opioid Use Disorder: All MOUD 45%, Buprenorphine/Bup-Naloxone 27%, Methadone 16%, Naltrexone 2%

Priority 10

- Pregnant and Parenting Individuals
- Baseline: SFY 2022, the total contracted number of Pregnant and Parenting Individuals (PPI) clients receiving PCAP case management services was 1,490 (an increase of 81 client slots).
- Target/Outcome:
  - First-year Target: SFY 2024 - Increase the number of Pregnant and Parenting Individuals (PPI) clients receiving PCAP case management services by 56 client slots, totaling to a maximum contracted amount of 1,546 client slots statewide.
  - Second-year Target: SFY 2025 - Maintain the number of Pregnant and Parenting Women (PPW) clients receiving PCAP case management services.

Priority 11

- Tuberculosis Screening
- Baseline: As of July 1, 2022, Tuberculosis screening and education is a continued required element in the BH-ASO contract for SUD treatment services.
- Target/Outcome:
  - First-year Target: For SFY 2024, ensure TB screening plans continue to be in contract with each of the ten BH-ASOs.
  - Second-year Target: For SFY 2025, review TB screening plans prior to the BH-ASO amendment and update as needed to ensure screenings and education services are being provided during SUD treatment services.

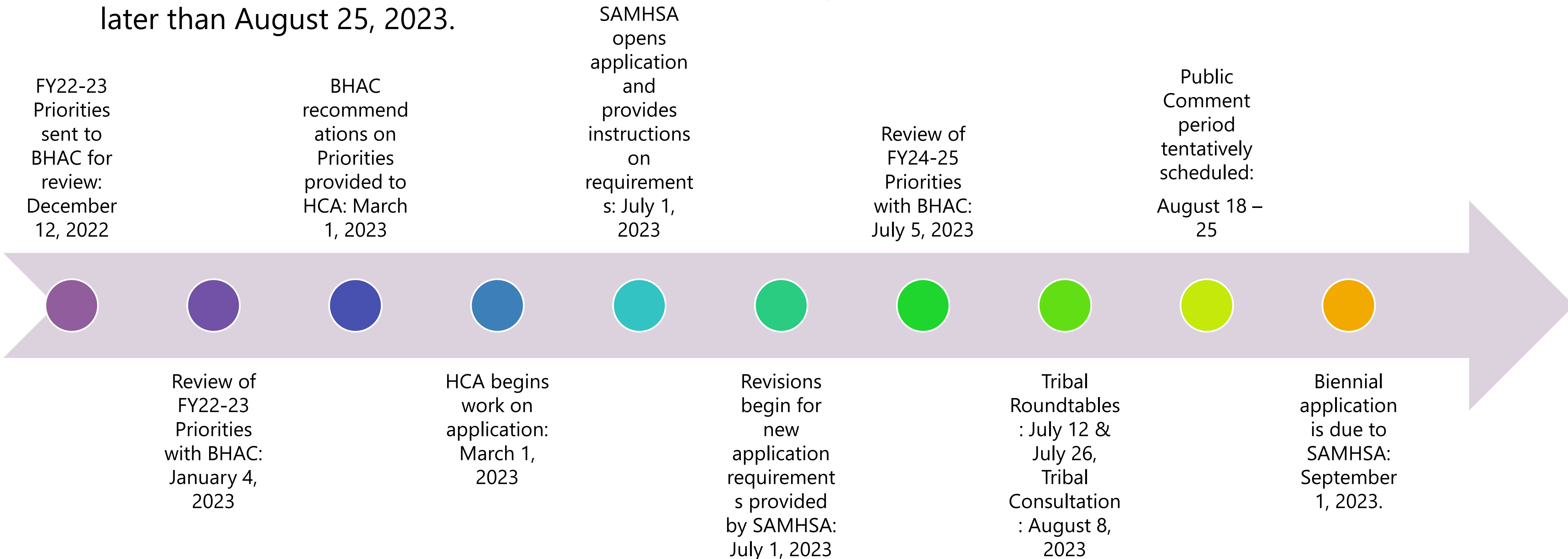
Priority 12

- Workforce Innovation – New priority based on BHAC recommendations
- Baseline: As of July 2023, zero staff trained.
- Target/Outcome:
  - First-year Target: 20 contract managers complete a training module on incentivizing workforce in performance-based contracts.
  - Second-year Target: Workforce training for contract managers is available on HCA LMS. Contract managers are encouraged to complete the training.

Questions? Concerns?

Next Steps

Please submit recommendations for updates and changes to the priorities and application narrative no later than August 25, 2023.



Recommendations may be submitted via email to DBHRBlockGrant@hca.wa.gov

Questions?

Washington State Health Care Authority

Contact us

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Washington State Behavioral Health Advisory Council
2024 – 2025 SABG and MHBG Recommendations
August 18, 2023

Priority #1

A. **Recommendation:** DBHR should find a way to be more collaborative vs hierarchal with their relationship to tribes
B. **Recommendation:** This priority needs data reference/ citation.
C. **Recommendations:** Remove:
   1. "Each tribe submits quarterly fiscal and programmatic reports to HCA."
   2. "HCA coordinates a biennial desk monitoring review with each Tribe as negotiated through a formal consultation process."

HCA Response:
HCA values our collaborative relationship with Tribes through our government-to-government work through HCA's Office of Tribal Affairs and their close partnership with Tribal governments.
HCA sent a Dear Tribal Leader Letter with accompanying materials for review April 6, 2023, and conducted a follow-up 90-minute listening session with tribes in May 2023 prior to entering the official application process to ensure we were collaborative from the start.
Entering the application process HCA conducted two 90-minute Round Tables in July 2023, and a 2-hour consultation session in early August 2023, slides containing feedback received and how we addressed each are attached.
HCA has thoroughly vetted the language in the priorities with Tribal Leaders through this collaborative consultation process and will be retaining the language as is.

Priority #3

Discussion Point #1:
The goal for this priority for the last three years the goal was 3584, this year it has been reduced to a goal of maintaining 1,900.

Recommendation:
A. Create a pathway for collecting qualitative data for what is causing barriers and access to care.

HCA Response:
It is a Federal SAMHSA requirement that these priorities reflect quantitative data to report actual numbers.
HCA acknowledges the need for the qualitative work on barriers and access to care and is actively seeking the qualitative data where possible. We have also taken the recommendation of BHAC to develop a workplan for collecting qualitative data in the future. A note: qualitative data collection is incredibly costly and administratively burdensome for the state, providers, and individuals served. HCA is sensitive to this and

seeking avenues to collect this information consistently with the least administrative burden possible.

B. Conducting an impact analysis of what the impact of what impact recent closing of youth SUD facilities is having.

HCA Response:
HCA's Prenatal through 25 team has been holding regular listening sessions with youth SUD facilities and collecting qualitative information from those sessions to inform an analysis of the impact of recent closures.

Priority #4

A. Recommendation: Set a percentage of those trained who are BIPOC or have a way to track it with the outcome measurements.

HCA Response:
HCA will look into our self-disclosed BIPOC peer metrics and work on establishing a specific goal for the FY2026 application. In the interim, we will prioritize reporting on the measurement of self-disclosed BIPOC peers with our annual progress report narrative. HCA can only report on peers who self-disclose their demographics, some decline to disclose.

B. Recommendation: Priory 4- states that they want to increase SUD certified Peers but lists below as "trained peers" if measuring for certified peers, the language will need to change.

HCA Response:
HCA does capture certified, but the language is noted the way it is because we also capture those in process of testing or retesting when we capture data.

Priority #5

A. Recommendation: The language in this priority is inconsistent. It is unclear if the goal is to "Maintain", "Improve" or "Increase." This needs to be clarified.

HCA Response:
Acknowledged and adjusted all language to maintain.

B. Recommendation: Priority 5 states the goal is to "increase" outpatient Mental Health services to youth with Serious Emotional Disturbance, but the baseline and goal numbers are the same as current numbers. This needs to be clarified.

HCA Response:
Acknowledged and adjusted language to maintain.

C. Discussion: This priority is going to be directly tied to supporting the workforce. It is incredibly difficult to find MH outpatient providers especially as it relates to SED.
Acknowledged and want to note the importance of workforce need for all the priorities which is a key reason that HCA added priority 12 on workforce efforts this year.

Priority #6

A. Discussion: We appreciate that the numbers measuring success has the number of sites, and showing the increase in services provided is linked to the increase in providers.

HCA Response:
Thank you.

Priority #7

A. Recommendation: Clarify the language in this priority's' goal to either "maintain" or "enhance/increase".

HCA Response:
Acknowledged and will adjust to maintain.

Priority 8

A. Recommendation: This priority would be more effective if it encompassed more than housing and employment. It should include more services for long term care/recovery aligned with achieving social determinants of health.

B. Recommendation: Create a way to track qualitative data to see what barriers there are to those experiencing homelessness accepting services

HCA Response:
HCA acknowledges the need for the qualitative work on barriers and access to care and housing services and is actively seeking the qualitative data where possible.
A note: qualitative data collection is incredibly costly and administratively burdensome for the state, providers, and individuals served. HCA is sensitive to this and seeking avenues to collect this information consistently with the least administrative burden possible.

Priority #9

Discussion: Increase availability of Sublocade (repeat recommendation)
On April 4th, 2022, the Washington Department of Health reported a provisional 66% increase in drug related overdose deaths over 2 years (Overdose deaths in Washington topped 2,000 in 2021 and continue to rise Washington State Department of Health) and according to the Seattle Times in June 2023, "Data from the Centers for Disease Control and Prevention shows Washington had the biggest increase in drug overdose deaths of any state in the US in the latest 12-month reporting period, ending Jan. 31. "Our overdose deaths soared 24% — by far the worst increase in the nation." Most of this increase is due to fentanyl misuse.

Studies in the last several years, one of which was provided by the Council to DBHR, year have increasingly shown that Sublocade, an injection which lasts 30 days, is the most effective MOUD treatment for fentanyl and other opioid misuse. However, it continues to be difficult to obtain or rarely prescribed.

Recommendation:

A. Increase access to Sublocade to support withdrawal management and ongoing recovery from OUD.

HCA Response:
Thank you for the recommendation, we are actively working on strategies to increase access to sublocade. We plan to add to this priority in future applications once know more about our strategies moving forward.

B. Add Sublocade to the list of medications in the Goal of the priority area sub paragraph and add tracking data for Sublocade.

HCA Response:
We are unable to add Sublocade to the goal and the priority at this time, this recommendation is acknowledged, and HCA will continue working on increased access to Sublocade and utility accessibility for future applications.

Priority #10

A. **Discussion:** How does the objective of improving health help achieve the goal of receiving case management? It seems these two should be swapped.
Recommendation: Consider swapping the objective and goal they need to be swapped.

HCA Response:
Thank you for your recommendation.

The objective is: Improving health of pregnant and parenting individuals.

The objective can be reached through the goal which is: Increasing the number of pregnant and parenting individuals who need case management services receiving those needed and necessary services.

B. Discussion: The goal in this priority is to improve health, and one way of achieving that goal might be through case management. However, this impact would be minimized by focusing only on case management.
Recommendation: We recommend adding additional goals like improving Social Determinants of Health survey scores improve from admission to PCAP, and at discharge from PCAP services.

HCA Response:
Thank you for your recommendation, we will consider this for future applications.

Priority #12

A. Recommendation: Sort the list of training courses in alphabetical order.

HCA Response:
Thank you for your recommendation, completed.

B. Recommendation: Add to the list of trainings for workforce development "Gambling Disorder, problem gambling, and Gambling Counselor

HCA Response:
Thank you for your recommendation, we will consider this for future workforce planning as trainings are developed.

C. Recommendation: Consider changing the baseline numbers to be the number of Peer wellness coaches, WRAP, and Peer Crisis trainings completed instead of website traffic. In other words, outcomes should measure services delivered and workforce trained vs. website traffic. This would more accurately reflect workforce outcomes.

HCA Response:
Thank you for your recommendation, this is a new priority, and we will consider your input as this priority develops.

D. Recommendation: The priorities' objective is **"**To support awareness of and interest in behavioral health careers and ongoing training and education." We recommend this change to read more directly and forcefully with the intent of growing the MH/SUD Workforce.

HCA Response:
Thank you for your recommendation, this is a new priority, and we will consider your input as this priority develops.

E. Recommendation: Workforce Innovation is not a strong label for the priority. Consider changing it to previous year's priority "Workforce Challenges".

HCA Response:
HCA labeled this priority to focus on the positive of workforce innovation with full awareness of the need and challenges that the workforce is facing. Thank you for your recommendation, we have updated the priority to a new title of "Workforce Innovation and Challenges".

Priority #14

A. Recommendation: For strategies to obtain the objective, consider adding something per the BHAC meeting discussions around getting Naloxone kits into colleges/universities:

a. "Partner with WA colleges and universities to provide Naloxone kits and training for all campuses. Kits to be located with 1st Aid kits or near AED equipment. Training may be provided in conjunction with 1st Aid and CPR training."
b. "Partner with local 1st Responders to include Naloxone training in 1st Aid/CPR classes."

HCA Response:
Thank you for your recommendation, this is a new priority, and we will consider your input as this priority develops.

B. Recommendation: Add Sublocade and Methadone to the medications tracking under indicators.

HCA Response:
Thank you for your recommendation, this is a new priority, and we will consider your input as this priority develops.

C. **Recommendation** - Provide funding for education/training/testing/certification scholarships/grants for those pursuing MH/SUD

HCA Response:
Thank you for your recommendation, this is a new priority, and we will consider your input as this priority develops, and additional funding becomes available.

Discussion: Finally, if these goals are prioritized in importance of 1-14, I would suggest moving this one up.

HCA Response:
Priorities are not listed in order of importance; all priorities are of exceptional importance to the State.

General Recommendations related to gaps in services:

1. **Address the Primary Cause of SUD - Increase Trauma Care**

Discussion:
According to SAMSHA, the current success rate of achieving long term recovery from SUD is at about an average of 50%. However, a 2019 study of long-term recovery from OUD performed by the Recovery Research Institute was 1.2% to 2.2%.

Studies also show that between 60 to 80% of people with SUD/OUD have suffered from significant trauma in childhood or later. Neuroscience shows there is a direct relationship between trauma and the propensity for SUD. In fact, some SUD and trauma/PTSD experts, such as the author and treatment provider Dr. Gabor Mate considers trauma an **injury to the brain,** not a disease.

Currently, SUD treatment that addresses trauma is rare. It seems evident that the current treatment approaches are overlooking the primary cause of SUD and are focused only on the symptoms. The "injury" is not getting healed.

As Desmond Tutu said "There comes a point where we need to stop just pulling people out of the river. We need to go upstream and find out why they are falling in."

Until trauma informed care is fully available for the treatment of SUD/OUD, long term recovery will likely be ineffective for the majority of those seeking help. We believe this is a significant gap in services.

Recommendation: Increase access to, and availability of, trauma informed care within treatment settings through training and certification opportunities for staff.

HCA Response:
Thank you for the recommendation HCA continues to prioritize, promote, and fund trauma informed care trainings both for State staff and providers.

2. Securing Prescribed Medicines in Municipal Jails

Discussion:
The Washington State Department of Social and Health Services and Behavioral Health Administration /Office of Forensic Mental Health produced a document 'Best Practices for Behavioral Health Services in a Jail Setting (May 2020). In addition, a major focus of the Trueblood settlement is directed towards improving timely access to Forensic evaluations for those individuals requiring competency determination and restoration services. Note: This recommendation is not related to inmates in need of competency determinations or those in serious psychological distress requiring intensive medical intervention.

Across the state are municipal jails operated by city governments. It's understood that intake screening is used to identify the individual's needs. There are those individuals who do require medications for behavioral health conditions and would need family (or others) to bring them into the jail, as long as the inmate has a current prescription. If that prescription has lapsed, a timely appointment with a physician should occur. Facilitating an inmate's access to securing needed medications in a timely manner is critical.

Recommendation: Ensure all inmates municipal jails are able to secure needed medications in a timely manner.

HCA Response:
HCA continues to prioritize ensuring access to needed medications in jails, there is currently $5M in ongoing funding for MOUD treatment within jails. Funding is provided to a total of 17 jails, including 1 tribal jail.

Environmental Factors and Plan

Advisory Council Members

For the Mental Health Block Grant, **there are specific agency representation requirements** for the State representatives. States MUST identify the individuals who are representing these state agencies.

State Education Agency
State Vocational Rehabilitation Agency
State Criminal Justice Agency
State Housing Agency
State Social Services Agency
State Health (MH) Agency.
State Medicaid Agency

Start Year: 2024 End Year: 2025

Name	Type of Membership*	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Shawn Brannan	Persons in recovery from or providing treatment for or advocating for SUD services			
Tessa Clements	Parents of children with SED			
Christal Eshelman	Providers			
Clarissa Fletcher	Family Members of Individuals in Recovery (to include family members of adults with SMI)			
Robert Hopkins	State Employees			
Susan Kydd	Persons in recovery from or providing treatment for or advocating for SUD services			
Ruth Leonard	State Employees			
Vanessa Lewis	Family Members of Individuals in Recovery (to include family members of adults with SMI)			
Kielan Lynch	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Richelle Madigan	Parents of children with SED			
Katie Mirkovich	State Employees			
Marcia Mongrain-Finkas	Family Members of Individuals in Recovery (to include family members of adults with SMI)			
David Musser	State Employees			
Jenni Olmstead	State Employees			
Jolie Ramsey	State Employees			
Nelson Rascon	Parents of children with SED			

Tana Russell	Others (Advocates who are not State employees or providers)			
Jeff Spring	State Employees			
Michelle Tinkler	Others (Advocates who are not State employees or providers)			
Bridget Underdahl	State Employees			
Josh Wallace	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			josh@peerwa.org
Keri Waterland	State Employees			

*Council members should be listed only once by type of membership and Agency/organization represented.

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Footnotes:

Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2024 End Year: 2025

Type of Membership	Number	Percentage of Total Membership
Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	2	
Family Members of Individuals in Recovery (to include family members of adults with SMI)	3	
Parents of children with SED	3	
Vacancies (individual & family members)	3	
Others (Advocates who are not State employees or providers)	2	
Total Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services), Family Members and Others	**13**	**56.52%**
State Employees	9	
Providers	1	
Vacancies	0	
Total State Employees & Providers	**10**	**43.48%**
Individuals/Family Members from Diverse Racial and Ethnic Populations	6	
Individuals/Family Members from LGBTQI+ Populations	0	
Persons in recovery from or providing treatment for or advocating for SUD services	2	
Representatives from Federally Recognized Tribes	0	
Youth/adolescent representative (or member from an organization serving young people)	0	
Total Membership (Should count all members of the council)	**23**	

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Environmental Factors and Plan

22. Public Comment on the State Plan - Required

Narrative Question

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. § 300x-51) requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

- **a)** Public meetings or hearings? ○ Yes ● No
- **b)** Posting of the plan on the web for public comment? ● Yes ○ No

  If yes, provide URL:

  https://www.hca.wa.gov/about-hca/programs-and-initiatives/behavioral-health-and-recovery/block-grants

  If yes for the previous plan year, was the final version posted for the previous year? Please provide that URL:

- **c)** Other (e.g. public service announcements, print media) ● Yes ○ No

Please indicate areas of technical assistance needed related to this section.

None at this time.

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Footnotes:

Environmental Factors and Plan

23. Syringe Services Program (SSP) - Required if planning for approved use of SUBG Funding for SSP in FY 24

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2024

Narrative Question:

The Substance Abuse Prevention and Treatment Block Grant (SABG) restriction[1,2] on the use of federal funds for programs distributing sterile needles or syringes (referred to as syringe services programs (SSP)) was modified by the **Consolidated Appropriations Act**, 2018 (P.L. 115-141) signed by President Trump on March 23, 2018[3].

Section 520. *Notwithstanding any other provisions of this Act, no funds appropriated in this Act shall be used to purchase sterile needles or syringes for the hypodermic injection of any illegal drug: Provided, that such limitation does not apply to the use of funds for elements of a program other than making such purchases if the relevant State or local health department, in consultation with the Centers for Disease Control and Prevention, determines that the State or local jurisdiction, as applicable, is experiencing, or is at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, and such program is operating in accordance with State and local law.*

A state experiencing, or at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, (as determined by CDC), may propose to use SABG to fund elements of an SSP other than to purchase sterile needles or syringes. States interested in directing SABG funds to SSPs must provide the information requested below and receive approval from the State Project Officer. Please note that the term used in the SABG statute and regulation, *intravenous drug user* (IVDU) is being replaced for the purposes of this discussion by the term now used by the federal government, *persons who inject drugs* (PWID).

States may consider making SABG funds available to either one or more entities to establish elements of a SSP or to establish a relationship with an existing SSP. States should keep in mind the related PWID SABG authorizing legislation and implementing regulation requirements when developing its Plan, specifically, requirements to provide outreach to PWID, SUD treatment and recovery services for PWID, and to routinely collaborate with other healthcare providers, which may include HIV/STD clinics, public health providers, emergency departments, and mental health centers[4]. SAMHSA funds cannot be supplanted, in other words, used to fund an existing SSP so that state or other non-federal funds can then be used for another program.

In the first half of calendar year 2016, the federal government released three guidance documents regarding SSPs[5]: These documents can be found on the Hiv.gov website: **https://www.hiv.gov/federal-response/policies-issues/syringe-services-programs**,

1. **Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016** from The US Department of Health and Human Services, Office of HIV/AIDS and Infectious Disease Policy **https://www.samhsa.gov/sites/default/files/grants/ssp-guidance-for-hiv-grants.pdf** ,
2. **Centers for Disease Control and Prevention (CDC)Program Guidance for Implementing Certain Components of Syringe ServicesPrograms,2016** The Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention, Division of Hepatitis Prevention **http://www.cdc.gov/hiv/pdf/risk/cdc-hiv-syringe-exchange-services.pdf**,
3. **The Substance Abuse and Mental Health Services Administration (SAMHSA)-specific Guidance for States Requesting Use of Substance Abuse Prevention and Treatment Block Grant Funds to Implement SSPs** **http://www.samhsa.gov/sites/default/files/grants/ssp-guidance-state-block-grants.pdf** ,

Please refer to the guidance documents above and follow the steps below when requesting to direct FY 2021 funds to SSPs.

- **Step 1** - Request a Determination of Need from the CDC
- **Step 2** - Include request in the FFY 2021 Mini-Application to expend FFY 2020 - 2021 funds and support an existing SSP or establish a new SSP
  - Include proposed protocols, timeline for implementation, and overall budget
  - Submit planned expenditures and agency information on Table A listed below
- **Step 3** - Obtain State Project Officer Approval

Future years are subject to authorizing language in appropriations bills.

End Notes

[1] Section 1923 (b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-23(b)) and 45 CFR § 96.126(e) requires entities that receive SABG funds to provide substance use disorder (SUD) treatment services to PWID to also conduct outreach activities to encourage such persons to undergo SUD treatment. Any state or jurisdiction that plans to re-obligate FY 2020-2021 SABG funds previously made available such entities for the purposes of providing substance use disorder treatment services to PWID and outreach to such persons may submit a request via its plan to SAMHSA for the purpose of incorporating elements of a SSP in one or more such entities insofar as the plan request is applicable to the FY 2020-2021 SABG funds ***only*** and is consistent with guidance issued by SAMHSA.

[2] Section 1931(a(1)(F) of Title XIX, Part B, Subpart II of the Public Health Service (PHS) Act (42 U.S.C.§ 300x-31(a)(1)(F)) and 45 CFR § 96.135(a)(6) explicitly prohibits the use of SABG funds to provide PWID with hypodermic needles or syringes so that such persons may inject illegal drugs unless the Surgeon General of the United States determines that a demonstration needle exchange program would be effective in reducing injection drug use and the risk of HIV transmission to others. On February 23, 2011, the Secretary of the U.S. Department of Health and Human Services published a notice in the Federal Register (76 FR 10038) indicating that the Surgeon General of the United States had made a determination that syringe services programs, when part of a comprehensive HIV prevention strategy, play a critical role in preventing HIV among PWID, facilitate entry into SUD treatment and primary care, and do not increase the illicit use of drugs.

[3] Division H Departments of Labor, Health and Human Services and Education and Related Agencies, Title V General Provisions, Section 520 of the Consolidated Appropriations Act, 2018 (P.L. 115-141)

[4] Section 1924(a) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(a)) and 45 CFR § 96.127 requires entities that receives SABG funds to routinely make available, directly or through other public or nonprofit private entities, tuberculosis services as described in section 1924(b)(2) of the PHS Act to each person receiving SUD treatment and recovery services.

Section 1924(b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(b)) and 45 CFR 96.128 requires "designated states" as defined in Section 1924(b)(2) of the PHS Act to set- aside SABG funds to carry out 1 or more projects to make available early intervention services for HIV as defined in section 1924(b)(7)(B) at the sites at which persons are receiving SUD treatment and recovery services.

Section 1928(a) of Title XXI, Part B, Subpart II of the PHS Act (42 U.S.C. 300x-28(c)) and 45 CFR 96.132(c) requires states to ensure that substance abuse prevention and SUD treatment and recovery services providers coordinate such services with the provision of other services including, but not limited to, health services.

[5]***Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016*** describes an SSP as a comprehensive prevention program for PWID that includes the provision of sterile needles, syringes and other drug preparation equipment and disposal services, and some or all the following services:

- Comprehensive HIV risk reduction counseling related to sexual and injection and/or prescription drug misuse;
- HIV, viral hepatitis, sexually transmitted diseases (STD), and tuberculosis (TB) screening;
- Provision of naloxone (Narcan?) to reverse opiate overdoses;
- Referral and linkage to HIV, viral hepatitis, STD, and TB prevention care and treatment services;
- Referral and linkage to hepatitis A virus and hepatitis B virus vaccinations; and
- Referral to SUD treatment and recovery services, primary medical care and mental health services.

Centers for Disease Control and Prevention (CDC) Program Guidance for Implementing Certain Components of Syringe Services Programs, 2016 includes a **description of the elements of an SSP** that can be supported with federal funds.

- Personnel (e.g., program staff, as well as staff for planning, monitoring, evaluation, and quality assurance);
- Supplies, exclusive of needles/syringes and devices solely used in the preparation of substances for illicit drug injection, e.g., cookers;
- Testing kits for HCV and HIV;
- Syringe disposal services (e.g., contract or other arrangement for disposal of bio- hazardous material);
- Navigation services to ensure linkage to HIV and viral hepatitis prevention, treatment and care services, including antiretroviral therapy for HCV and HIV, pre-exposure prophylaxis, post-exposure prophylaxis, prevention of mother to child transmission and partner services; HAV and

HBV vaccination, substance use disorder treatment, recovery support services and medical and mental health services;

- Provision of naloxone to reverse opioid overdoses
- Educational materials, including information about safer injection practices, overdose prevention and reversing an opioid overdose with naloxone, HIV and viral hepatitis prevention, treatment and care services, and mental health and substance use disorder treatment including medication-assisted treatment and recovery support services;
- Condoms to reduce sexual risk of sexual transmission of HIV, viral hepatitis, and other STDs;
- Communication and outreach activities; and
- Planning and non-research evaluation activities.

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Footnotes:

We are not currently planning to use Block Grant funding for Syringe Services Programs.

Environmental Factors and Plan

Syringe Services Program (SSP) Information – Table A - Required if planning for approved use of SUBG Funding for SSP in FY 24

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2024

Syringe Services Program (SSP) Agency Name	Main Address of SSP	Planned Dollar Amount of SUBG Funds to be Expended for SSP	SUD Treatment Provider (Yes or No)	# of locations (include any mobile location)	Naloxone Provider (Yes or No)
No Data Available					

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Footnotes:

We are not currently planning to use Block Grant funds for Syringe Services Programs.