

Washington  
UNIFORM APPLICATION  
FY 2020/2021 – STATE BEHAVIORAL HEALTH ASSESSMENT  
AND PLAN  
SUBSTANCE ABUSE PREVENTION AND TREATMENT  
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

ASSESS THE STRENGTH AND NEEDS OF THE BEHAVIORAL HEALTH SYSTEM

*Provide an overview of the state's M/SUD 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.*

*The description should also include how these systems address the needs of diverse racial, ethnic, and sexual and gender minorities, as well as American Indian/Alaskan Native populations in the states.*

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.

Washington State continues to transform how it delivers behavioral health services by integrating the financing and delivery of behavioral and physical health care by 2020. Integration will improve prevention and treatment of behavioral health conditions. Integration, leading to better whole person care, should also 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, 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
- Intervention
- 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
- Pathological and problem gambling services

DBHR manages many funding sources that support the majority of 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 RDA, DBHR 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, treatment, 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.
- Expanding to full integration with primary care by 2020 with early and mid-adopter regions during the time until full implementation.
- 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.

DBHR provides prevention, intervention, inpatient treatment, outpatient treatment, and recovery support to people who are at risk for addiction or diagnosed with mental illness. In state fiscal year 2017:

- 179,500 clients participated in mental health treatment (36,300 received crisis services).
- 47,000 clients participated in substance use disorder treatment.
- 16,137 clients received direct services with community strategies reaching over 100,000 clients with substance use disorder prevention activities.
- 16,000 clients received Recovery Support, Engagement, and Outreach services.
- 1,100 clients received SUD Access to Recovery services.
- 350 peers and 150 parents and youth received Certified Peer Counseling (CPC) training through the Peer Support Program.
- 850 clients received Housing and Recovery through Peer Services (HARPS).
- 180 clients received Supported Employment Services
- Over 4,000 homeless individuals received outreach services through the Projects for Assistance in Transition from Homelessness (PATH) in conjunction with BRIDGES.

Total BHA expenditures in SFY 2017: approximately \$1.510 billion distributed as follows:

- Community Mental Health (MH): \$848.07 million
- Community Substance Use Disorder (SUD) treatment: \$313.69 million
- State Psychiatric Hospitals: \$348.97 million

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:

- 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:
  - Homeless or inappropriately housed
  - Involved with the criminal justice system
  - Living in rural or frontier areas of the state
- Members of traditionally underserved, including:
  - American Indian/Alaska Native population
  - Other Racial/ethnic minorities
  - LGBTQIA populations
  - 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 blend together to fund this entire system, including but not limited to Medicaid; general state funds; federal block grants; local/county sales tax funding; proviso funding such as Designated Marijuana Account funds; and a variety of smaller grants from federal government agencies such as the Substance Abuse Mental Health Services Administration (SAMHSA).

The term "behavioral health" is inclusive of mental health and substance use disorders, as well as co-occurring mental health and addiction. The behavioral health system spans the entire continuum of care, to include prevention, crisis services, mental health treatment, substance use disorder treatment, residential and inpatient services, and an array of recovery services and supports.

### Community Behavioral Health System - Overview

Washington's behavioral health system is divided into ten regions (<https://www.hca.wa.gov/assets/free-or-low-cost/19-0025.pdf>), with each region being administered by Behavioral Health Organizations or Managed Care Organizations. 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).

Over the past five years, the community behavioral health system has undergone considerable change. One of the most significant changes has been the integration of mental health and substance use disorder treatment. Additionally, Medicaid expansion allowed for a greater proportion of substance use disorder treatment to be provided under Medicaid. Then in 2016, Behavioral Health Organizations integrated mental health and substance use disorder services, transforming a two service delivery system into a one region wide system.

In 2018, the state legislature passed 2<sup>nd</sup> 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 consolidates 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.

Currently Washington State's behavioral health system is undergoing significant transformation by moving to full integration and whole-person care, integrating physical and behavioral health. With integrated managed care, a managed care plan coordinates and pays for both physical health and behavioral health services. By 2020, each region will offer a minimum of two or a maximum of five Managed Care Organizations. In addition, each region will have 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-ASOs hold the State-only and federal block grant contracts to provide services that are not covered by Medicaid.

#### Current Contracting Structure of the Community Behavioral Health System

The Washington Legislature (RCW 71.24.850) set forth two pathways for the integration of behavioral health and physical health care by January 1, 2020:

- 1) Behavioral Health Organizations (BHOs) as Prepaid Inpatient Health Plans with a purchasing model in which care for behavioral health (mental health and substance use) disorders for Medicaid beneficiaries is delivered through contracts between DSHS and the BHOs.
- 2) Fully Integrated Managed Care (FIMC) Regional Service Areas with a purchasing model through contracts between the Health Care Authority (HCA) and Managed Care Organizations (MCO) for both medical and behavioral health (mental health and substance use disorder services).

#### Behavioral Health Organizations (BHO)

As required by the Washington State Legislature, the substance use disorder (SUD) and mental health (MH) services were integrated into a behavioral health managed care benefit on April 1, 2016. This required the formation of regional BHOs that have at-risk contracts to deliver both substance use disorder and mental health services also known as Prepaid Inpatient Health Plans (PIHPs). The BHOs contract for direct services with local providers to provide an array of behavioral health services based on medical necessity, oversee the distribution of funds under the state managed care plan, provide utilization management and other administrative functions, and develop quality improvement and enrollee protections for all Medicaid clients enrolled in the BHO system. The capitated managed care behavioral health system gives the BHOs the ability to design an integrated system of mental health and substance use disorder care and subcontract with networks of community behavioral health agencies capable of providing high quality service delivery, which are age appropriate and culturally competent. This contractual structure is expected to improve behavioral health service outcomes and help to control the rate of financial growth while still requiring adherence to all state and federal requirements. BHOs may impose additional requirements on subcontractors as needed to ensure appropriate



management oversight and flexibility in addressing local needs.

In addition to the managed care program for MH and SUD services, the BHOs hold the State-only and federal block grant contracts to serve those individuals that are not covered by Medicaid or to fund services that are not covered by Medicaid.

The BHOs also collaborate with Washington's Apple Health Medicaid-funded managed care program to ensure coordinated care for enrollees. The Apple Health managed care program provides a full array of medical services as well as mental health services for those who do not need higher levels of care for mental health services.

#### Fully Integrated Manage Care (FIMC)

As part of the same Legislation that required the integration of substance use disorder and mental health services, the state was required to move toward full integration of all physical and behavioral health under integrated managed care contracts by January 1, 2020.

In order to start the process of moving towards all regions being integrated for the full continuum of care, one region of the state became an "early adopter" to pilot full integration. This was the Southwest Region and includes two counties, Clark and Skamania. Two Managed Care organizations were awarded contracts for the Medicaid program and an Administrative Service Organization was awarded a contract to manage state funds as well as the federal block grant programs.

In January 2018 one additional region (North Central), and January 2019 four additional regions transitioned to full integration (King, Pierce, Spokane, and Greater Columbia). One additional region will transition in July of 2019 (North Sound). The last three will transition January 1, 2020 (Salish, Great Rivers, and Thurston Mason) resulting in full integration across WA State.

Effective July 1, 2017, the AI/AN population has the option of receiving mental health and substance use disorder treatment through the Medicaid managed care system or choose to receive their services through a fee-for-service delivery system.

#### American Indian/Alaska Natives

In Washington, individuals who self-identify as American Indian/Alaska Native (AI/AN) and are a Medicaid enrollees are exempt from the integration of behavioral health treatment (SUD and MH) services provided by managed care programs. The exemption for substance use treatment began in April 2016 and then expanded to mental health in July 2017. The exemption of behavioral health services from managed care for AI/AN individuals was in response to concerns expressed by the Washington State Tribes and Urban Indian Health Organizations, as well as in collaboration with the Centers for Medicaid and Medicare Services (CMS). 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 provider, 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.

### 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
- Tribal governments and other tribal partners

### 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. The Division of Behavioral Health and Recovery (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
- 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

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

#### State Tribal Agreements and Contracts with Tribes

In the upcoming biennium the Health Care Authority has updated and enhanced funding opportunities to tribal governments to support a variety of services along the spectrum of mental health promotion and substance use disorder continuum. These funding opportunities include a variety of state and federal funding resources that may be braided to support a comprehensive approach. 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.

Through the transition of the DBHR to the HCA, the Agency has developed a newly established contracting process with each tribe that is modeled after the DSHS Contract Consolidation program. This Indian Nation Agreement considers tribes as sovereign governments that may be eligible to receive various funding resources from the Health Care Authority. Each program will have an Indian Nation Program Agreement. The goal of the funds provided for SUD and Mental Health Promotion are to bring all funding resources together. These resources are the SABG SUD, SUD Tribal Opioid Response, State Opioid Response grant, Dedicated Marijuana Account, and Mental Health Promotion state funds. Tribes may choose which funding they need to support their programs. DBHR has expanded their programing scope to allow for tribes to utilize funding for a variety of prevention, treatment and recovery supports modalities. They choose which funds and services to support through one tribal behavioral health plan under the Indian Nation Program Agreement for BH.

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 is 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.

In addition to funding provided by the DBHR block grant funds, Tribes can also contract with Behavioral Health Organizations/BH-Administrative Services Organizations. DBHR contracts with three BHOs and 6 BH-ASOs across the state to provide outpatient and residential SUD and MH services. Contracting opportunities through BHO/BH-ASOs are also available to the Urban Indian Health Programs as well.

These contracts are negotiated between the BHO/BH-ASO and the Tribe or Urban Indian Health Program.

Separate from block grant funding, the Tribes receive Medicaid funding based on the Federal Memorandum of Agreement (MOA), and the rate is based on the Indian Health Services (IHS) Encounter Rate. Under the terms of the federal MOA, tribally owned clinics authorized through IHS who serve Tribal members receive reimbursement at 100 percent of the federal encounter rate for substance use disorder treatment services. In addition, authorized Tribes can serve non-tribal members and receive 50 percent of the encounter rate for substance use disorder treatment services. In coordination with HCA, DBHR offers technical assistance, training, and consultation to tribal Federally Qualified Health Centers (FQHC) and Tribal 638 mental health programs on billing procedures and Medicaid regulations.

Since 2016 DBHR, HCA, Indian Health Services (IHS) Direct, Tribal 638, and Urban Indian Health Programs (I/T/U) system of care worked together to implement the fee-for-service system for SUD and MH treatment services for AI/AN individuals covered by Medicaid. Medicaid funding pays for outpatient and residential SUD and MH services for these clients who receive these services from a fee-for-service (FFS) provider. For those AI/AN clients who are non-Medicaid, they are able to receive services from their tribal behavioral health provider and/or from a non-tribal provider within the BHO system of providers. BHOs also use block grant funding to pay for the SUD and MH services for these non-Medicaid clients. In the past biennium, the North Sound BHO and North Sound Region tribes put on their annual Tribal Behavioral Health and Opioid Symposium Conference with main speakers and workshops on topics that are culturally relevant to the Washington State Tribes. The Conference was titled “The Power to Heal, Cultural Tradition in Wellness”, and the main speakers and workshop topics were about healing from historical trauma, the need for cultural tools, transitional living programs, advocacy, and wellness – recovery from trauma. The second day was focused on Medically Assisted Treatment for those who have Opioid Use Disorder, Good Samaritan Laws, 911 for drug overdose and treating the historical trauma in Native Americans as the root cause to mental health and substance use disorder problems. Currently the tribes are working on putting either/or an tribal evaluation and treatment facility to address mental health (E&T) and substance abuse disorders (Secure Detox) that addresses crisis placements that is culturally relevant to their AI/AN population. The other consideration is to contract with the Area Service Organization or Behavioral Health Organization to have a few beds in existing facilities adding the cultural aspect to the treatment to ensure they are receiving culturally relevant treatment to the tribal members.

Since the move to Health Care Authority from Department of Social and Health Services, the Tribal Coordination Plans (used to be the Tribal 7.01 Plans) have been going on with each tribe – some once a year, some quarterly, and some semi-monthly depending on their needs and requests. These tribal plans are geared around prevention, mental health and substance use disorders and what each tribe needs to keep their programs functioning or to start up programs, move G2G funding into prevention so they need to change their plan or to move more funding into treatment due to increased opioid use or need for treatment services.

There has been an increase in requests to get trainings and technical assistance on the Washington State Electronic Reporting Systems. The trainings are scheduled and are completed including any technical assistance needed to help the programs continue functioning until a new system is found.

On-site reviews are scheduled on a to insure the Tribal Treatment programs are compliant to all state and federal laws regarding the SAPT Block Grant and Medicaid. According to the Office of Management and Budget (OMB) Circular A-133, HCA/DBHR is considered a primary pass-through entity and the Tribes become secondary pass-through entities having the same responsibility for enforcing the audit requirement among their subcontractors.

The Public Health Service Act (42 USC 300x-21-66) authorized the Substance Abuse Prevention and Treatment (SAPT) Block Grant and specifies requirements to the use of these funds which is part of the State Plan. The intended use of the Substance Abuse Prevention and Treatment Block Grant Funds are created on the States plan which is based on a needs assessment, resource availability and State priorities.

### Primary Prevention Services

HCA/DBHR 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.

Funding is primarily disseminated via:

- County contracts.
- Community-based organization contracts.
- Inter-local contracts.
- Consolidated Intergovernmental Agreements (IGA) with Washington State Federally Recognized Tribes through the Office of Indian Policy (OIP).
- Personal service agreements for services such as workforce development training and capacity building.

Most services provided are structured evidence-based drug and alcohol prevention curriculum for youth and parenting classes for adults. Information dissemination efforts and alternative drug-free activities are permitted as part of comprehensive program plans. 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. DBHR 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 marijuana 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.

DBHR contracts with the Office of Superintendent of Public Instruction (OSPI) for the placement of Student Assistance Professionals 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 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 Student Assistance Professional also provide problem identification and referral strategies through referrals to mental health and substance use disorder treatment 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.

Additionally, Washington State's community-based organizations (CBOs) grantees serve high-need communities to provide quality and culturally competent replications of evidence-based, research-based, and promising substance use disorder prevention programs. This statewide process provides services using a list of DBHR approved prevention programs to ensure evidence-based and research-based programs are implemented. Organizations are encouraged to partner with Community Prevention and Wellness Initiative (CPWI) community coalitions, or other existing community coalitions when possible, and follow the same reporting requirements as other prevention service providers.

## ADULT BEHAVIORAL HEALTH SYSTEM

### Mental Health

Currently, the BHOs and the FIMC, through contracts with community mental health agencies, provide a complete array of services to adults with serious mental illness (SMI) who meet the Access to Care standards (diagnosis and level of functional impairment) and standardized medical necessity criteria. Please note that as of January 1, 2020, the remaining BHOs will transition to a fully integrated care model and cease to exist. The Access to Care standards will no longer be applicable. The list of possible services may include brief intervention, crisis services, family treatment, freestanding evaluation and treatment, individual and group treatment, high intensity treatment, medication management and monitoring, residential treatment, and stabilization services.

BHOs and FIMC regions contract with provider groups and community mental health agencies. Each BHO and FIMC network serves all Medicaid enrollees within its geographical area. Crisis services are available to all residents of the state, without regard to funding or Medicaid eligibility.

The BHOs and BH ASOs administer the Involuntary Treatment Act (ITA) and the crisis response system for all people in their service area, regardless of income or eligibility. 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 consumer. 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 non-hospital evaluation and treatment facilities (E&Ts) authorized by the BHOs and ASOs. Some inpatient resources are certified for short-term (up to 17 days) ITA services.

In addition to community based services, DSHS's BHA also operates two state psychiatric hospitals which serve individuals who are civilly committed under RCW 71.05 for court ordered 90- or 180-day civil commitments. The state hospitals provide evidence-based professional psychiatric, medical, habilitative, and transition services within a Recovery of System of Care model and coordinates with the BHOs to transition clients back into the community. The state psychiatric hospitals also serve individuals committed under RCW 10.77 who are court-ordered criminal defendants needing competency and restoration services. Jail and community-based competency evaluations are also offered locally.

### Substance Use Disorder Treatment

The FIMCs, and BHOs through contracts with community substance use disorder agencies, provide a complete array of quality treatment services to 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 BHO's contracts with provider groups and community substance use disorder agencies. Each BHO and FIMC serves all Medicaid enrollees within its geographical area except for AI/AN who have opted out of receiving SUD services through the BHOs but 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 and education. 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 who are addicted to substances and their families. There are currently 69 intensive inpatient residential providers with a total capacity of 2,146 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 seven adult long-term residential providers with a total capacity of 135 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.

### Medication Assisted Treatment

Medication Assisted Treatment (MAT) 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 MAT 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 (MAT)—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 vivitrol. 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 are clinically managed residential facilities that have limited medical coverage. 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.

## 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:

- Legislative direction for movement to fully integrated purchasing region with a multi staged integration from 2016 and ending with the final regions in 2020.
- 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. Access to Care Standards highlights the need to evaluate functional need in all domains.
- Washington State's First Episode Psychosis Initiative, 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.
- As a part of our Washington Administrative Code 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 Service Organizations. 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 these six youth-serving state partners: Rehabilitation Administration-Juvenile Rehabilitation (RA), Department of Health (DOH), Children's Administration (CA), Health Care Authority (HCA), Office of Superintendent of Public Instruction (OSPI), and Developmental Disabilities Administration (DDA).

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 are required to implement at least 15 percent Evidence/Research-Based Programs and/or Practices (EBPPs) into the Behavioral Health Organization contracts for children/youth. The required percentage increases yearly with 2017 contractual requirements ending at 30 percent. The intention is steadily increase the percentage of EBPP services for children and youth 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 psychiatrist 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.

#### 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.

### AN OVERVIEW OF THE CONTINUUM OF CARE

DBHR includes services and program support for behavioral health, prevention/promotion, and early intervention, 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 extends 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 was 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 BHO and FIMC 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. Medical necessity and Access to Care Standards (ACS), established by the department and approved by the Centers for Medicare and Medicaid Services (CMS), govern access to services for mental health. In general, to meet the ACS criteria, a person must have a covered diagnosis, significant functional impairment, 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 new behavioral health recovery help-line. The Washington Recovery Help-Line 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 criteria 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 will become Designated Crisis Responders and will 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. RCW 70.96A and the role and functions of the Designated Chemical Dependency Specialist will expire April 1, 2018.

If an AI/AN who is served by a tribal behavioral health provider is in crisis, DBHR requires that the BHOs 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.

#### 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 Dep. of Health (DOH), whether services are provided to individuals in their local community or in another region. If an individual meets criteria 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.

#### Pregnant Women and Women with Dependent Children

Pregnant and Parenting Women (PPW) 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 PPW Substance Use Disorder Outpatient Treatment Services, PPW Substance Use Disorder Residential Treatment Services, PPW Housing Support Services, Therapeutic Intervention for Children,

intensive in-home case management services with the Parent-Child Assistance Program (PCAP), and the Washington State Fetal Alcohol Syndrome Diagnostic and Prevention Network (WA FASDPN).

#### 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 states.

#### Office of Consumer Partnership

The Office of Consumer Partnership (OCP) currently has a team of twelve who have various types of experience/perspectives as individuals with lived experience of behavioral health systems in the state. The members provide a voice for children and adults receiving mental health and substance use disorder treatment services. The OCP is a priority within DBHR with a clearly defined purpose. Some key elements include:

- Providing leadership as a member of the Executive Management Team.
- Advocating for both substance use disorder and mental health individuals with lived experience.
- Ensuring, by policy and contractual requirements, that advisory committees and planning groups include meaningful consumer voice.
- Assisting in the development and support of emerging consumer leadership.
- Supporting consumer networking and leadership training at DBHR-supported conferences and trainings.
- Assisting with recovery-oriented training, including Mental Health First Aid and Wellness Recovery Action Plan training.
- Promoting recovery values statewide through DBHR leadership and involvement in behavioral health systems and the community.

## WORKFORCE DEVELOPMENT

#### Tribal Behavioral Health Conference

Washington maintains a Government to Government relationship with Federally Recognized Tribes. As the state transitions into managed care, and the tribal behavioral health system remains a fee-for-service system, ongoing communication collaboration, and education for tribal and non-tribal providers is essential.

The purpose of the Tribal Behavioral Health Conference is to provide a forum for health professionals from Tribes, Urban Indian Health Organizations, all Indian Health Care Providers, Behavioral Health Organizations, Community Mental Health Agencies, Accountable Communities of Health, and others to share best practices for the delivery of mental health and substance use disorder treatment services for

American Indians (AI) and Alaska Natives (AN) in Washington State, as well as providing a forum to discuss the legislatively-driven directive to integrate behavioral health and physical health services by 2020.

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

- North Sound Tribal Behavioral Health Conference hosted by the NS Behavioral Health Organization 2018 & 2019
- Tree of Healing Conference hosted by the Kalispel Tribe of Indian 2018 & 2019
- Tribal Prevention Gathering 2018 & 2019
- ASAM Trainings for Tribes and Urban Indian Health Programs 2019
- Wrap-Around with Intensive Services (WISe) training for Tribes 2018
- WISe curriculum adaptation project 2019
- Trauma Informed Approaches training specific for Tribal and AI/AN communities 2019
- Native American Substance Abuse Prevention Skills Training (NA-SAPTS) 2018 & 2019
- Tribal Designated Crisis Responder Training 2019
- Substance Use Disorder and Mental Health Promotion Online Data Reporting System (Minerva) several training in 2018-2019

DBHR provides funding for the following additional annual statewide conferences and trainings:

#### Co-Occurring Disorder Conference

The annual Washington State COD and Treatment Conference will be held in Yakima at the Convention Center on October 7<sup>th</sup> and 8<sup>th</sup>, 2019. Ethics and Suicide Prevention will be provided on October 6<sup>th</sup>, 2019. The conference provides attendees (including consumer and family) with information regarding current legislation related to mental health care and services, current resources, and treatment methodologies.

This year, the COD conference plenary sessions focus on engaging traditionally difficult to engage groups by reframing care to their needs and providing a better work life balance. In addition, the plenary focus areas will also have workshops addressing, Trauma, Medication Assisted Therapies, youth and gender issues, special populations, 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. This year's Conference theme was "Cultivating Community Solutions" and was held June 13-15, 2019 in Vancouver Washington.

The conference audience included mental health professionals in areas of aging, corrections, developmental disabilities, children's services, primary health, substance use disorder and other specialties including consumers and consumer advocates, administrators, staff of treatment agencies and other stakeholders. Over 350 consumers and consumer advocates, including Behavioral Health Advisory Committee members, were in attendance.



### Saying It Out Loud Conference

The Saying it Out Loud (SIOL) Conference is planned in partnership with the Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ+) communities, experts in the behavioral health field, as well as other state agencies including Aging and Long-Term Support Administration (AL TSA), Dept. of Children, Youth and Families (DCYF), Juvenile Rehabilitation (JR) etc. This conference brings together professionals from the diverse fields of social work, mental health, substance use disorder treatment, and substance abuse prevention, physical healthcare etc. to focus on the impacts of substance use disorder and mental health on LGBTQ+ 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 LGBTQ+ communities, community providers, and state agencies to better support and care for individuals who identify as LGBTQ+.

This year's conference was held at the Greater Tacoma Convention and Trade Center in Tacoma, WA on Monday April 29<sup>th</sup>, 2019. There were approximately 535 participants in attendance from around the state of Washington. The Keynote, Dr. Leticia Nieto spoke to the psychological dynamics of oppression and privilege, intersectionality and finding liberation and illumination and using it for change. Workshops were offered to increase and encourage awareness, communication, and improve service delivery for LGBTQ+ individuals of all ages. Community providers and agencies throughout the state also attended as exhibitors to share information and resources, including a book vendor.

Each year, experts share the latest research, best practices and information with conference attendees, having one mission, and that is to improve behavioral health care needs, provide the highest quality of care, with the health and wellbeing of LGBTQ+ individuals in mind.

### Prevention Summit and Youth Forum

The Washington State Prevention Summit (Summit) provides an enriching and culturally competent training and networking opportunity for youth, volunteers, and professionals working toward the prevention of substance abuse. Held in the fall, the two-day conference event includes high-quality workshops, forums, and hands-on learning opportunities to meet a variety of needs, including professional development for prevention providers. Specifically, the Summit provides education and training to prevent alcohol, tobacco, marijuana, opioid, and other drug use, with an emphasis on preventing underage drinking and prescription drug abuse. 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 (ages 12-18).

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.

## Peer Support Training

### *Increase Peer Workforce*

Washington State's Peer Support Program began in 2005 training mental health individuals with lived experience to become Certified Peer Counselors. The program has expanded to train additional certified peer counselors to meet workforce needs, to provide continuing education of certified peer counselors, and to develop programs to address underserved populations.

Peer support is now 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 5 full time staff. DBHR has been expanding and developing a peer support program for individuals with Substance Use disorders. The growth of the program require us to be strategic about the training and certification program. We have been working to develop a database for peer support training. This database will allow us to increase our efficiency and better serve the behavioral health system.

DBHR received technical assistance through SAMHSA to development a plan to utilize Medicaid for delivering peer services within the substance use treatment system. In calendar year 2018, DBHR certified over 475 people as Peer Counselors, including 58 SUD Peers. To date in 2019 we have already trained an additional 89 Peers with SUD lived experience. We expect this number to increase substantially as the SUD treatment providers begin to develop their peer programs.

DBHR piloted and implemented a successful PATHFINDER project which initiated SUD peers on homeless outreach and engagement teams.

### *Stakeholder Work group*

In 2018 DBHR created a workgroup and strategic plan to implement SUD Peer Services. The 40 person workgroup consisted of external and internal stakeholders, including; SUD providers, Tribes, Peer Run Community organizations, and system partners. The workgroup held more than 25 meetings, beginning with a one day summit in May 2018, then met 1-2 times per month through April 2019 and currently meet once each month.

### *Strategic plan to add SUD Peers to behavioral Health System*

In 2017, Senate Bill 6032 authorized the development of an SUD Peer program. With input from the stakeholder workgroup, DBHR developed a strategic plan which included amending the Medicaid State plan, updating rules (WAC), revising the Service encounter definitions, amending contracts, and to update numerous other processes necessary to add SUD Peers to the Substance Use Treatment System as a Medicaid billable service.

Currently, we have submitted a State Plan Amendment to Medicaid, new administrative rules (WAC) are being implemented and we are partnering with our licensing agency to reduce barriers to employment. Certified Peer Counselor services will be able to be reimbursed by Medicaid for Substance Use Treatment programs by mid-2019.

### *Update Curriculum and Training*

Our curriculum has been revised to include adult, youth and family Mental Health and Substance Use Peers. The SUD Stakeholder workgroup and the Peer Advisory group had opportunities to provide

revision feedback. Revised curriculum was completed in several stages and we have begun to train SUD peers. The final stage of the process will include using the updated curriculum with special sessions including facilitation by SUD peer providers.

We are in the process of creating an additional training and certification pathway for peers who have been trained in the CCAR Recovery Coach Model. We are requesting bids through a competitive process for the development of a “bridge training” that will provide the curriculum needed to advance a recovery coach to a certified SUD Peer Counselor.

#### *Additional Workforce Continuing education, training and preparation for SUD Peer Services*

In addition to certification training, peer counselor continuing education trainings include Supervision, Ethics, Documentation, Trauma Informed Care, and Wellness Recovery Action Plan. In 2018 DBHR held the 3<sup>rd</sup> annual Peer Pathways Continuing Education conference. This conference was attended by 325 peers and included tracks on SUD peer support including SUD Peer Services surveys and a focus group held in partnership with SAMHSA TA team. 2019 will be the 4<sup>th</sup> Annual Peer Pathways Continuing Education Conference for working Peers. This conference has grown every year and we expect over 400 Peers to attend. Conference presenters include National and Local Peer experts with lived experience in Mental Health and Substance Use Recovery.

In order to meet the increasing demand for training, Train the trainer events for all trainers, including new SUD peer trainers have increased by 50%. We have also created a training pathway through a mentoring toolkit, the toolkit include core competencies for trainers and a system for coaching. This toolkit is in the final draft stages and should be implemented by July 2019.

The Peer Support program also provides technical assistance and training to Behavioral Health Organizations/Agencies, Community Mental Health Agencies, Substance Use Treatment programs, and Tribes, as requested, on how organizations can operationalize Peer Supports. This trainings include Supervision, Documentation, and Recovery. These technical assistance and training is customized to meet each organization’s needs.

## 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:

#### *Washington State Targeted Response to the Opioid Crisis (WA-STR)*

May 1, 2017 through May 30, 2019

The WA-Opioid STR Project is designed to address the state’s opioid epidemic by implementing four major goals: add five new Community Prevention Wellness Initiatives sites; increase prescriber/consumer education, complete an evidenced-based practice analysis, and implement a statewide public education campaign; 2) Treatment/Recovery Support- implement six Hub and

Spoke Projects, provide a minimum of five MAT trainings, design/implement a Substance Use Disorder Peers initiative, increase treatment access with financial hardship initiative, reduce correctional recidivism for adults and juveniles, develop a low-barrier Buprenorphine pilot to increase treatment access, engage a minimum of five tribes to design a tribal treatment information campaign and operate Mobile MAT clinics; 3) reduce opioid overdoses by enhancing Naloxone distribution; and 4) enhance the Washington State prescription drug monitoring system.

The Washington State allocation is \$11,790,256 per year/Two-year grant. This grant includes 18 projects – 9 prevention and 9 treatment:

- Primary and Secondary Prevention \$2,355,768
- Treatment/Recovery Expansion \$8,844,975
- Total amount for program development \$11,200,743

## Prevention

### 1. **Prescriber/Provider Education** (\$80,000)

Host two (east side and west side of the State) 2-day symposium events for Washington State dental prescribers and oral health care providers who commonly treat youth and adults with injuries and acute pain. The events will focus on opioid prescribing practices and guidelines. Washington State Labor and Industries (L&I) is providing planning support for symposium content and speakers.

### 2. **UW TelePain** (\$40,619)

Provide partial funding to the University of Washington (UW) for a weekly TelePain program that provides access to a multidisciplinary panel of experts that 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.

### 3. **Public Education Campaign** (\$868,149)

Work with the DSHS Communications Office and additional media vendors as needed to design, test and disseminate various public education (cable, radio, newsprint, and social media) messages that promote public education with tribes to meet community needs.

### 4. **Safe Storage Curricula and Training** (\$20,000)

Innovative pilot project to integrate prescription drug misuse and abuse prevention education with existing state services that parents and caregivers receive. This project will engage state agencies to submit project proposals up to \$5,000 to establish internal capacity to provide prescription misuse/ abuse prevention education and messaging to clients in the long-term.

### 5. **Prevention Workforce Enhancements** (\$60,000)

Enhance funding support to Annual Washington State Prevention Summit and Spring Youth Forum. This support will increase the availability of educational opportunities for youth and

prevention professionals (and related fields) by providing presentations and workshops geared toward opiate misuse and abuse prevention.

**6. Community Prevention and Wellness Initiative (CPWI) Expansion (\$752,000)**

Using an evidenced based school and community process DBHR will develop CPWI in five (5) high-need communities to support local strategic planning and decision-making to focus on addressing local needs by implementation of evidence-based strategies and programs, as well as, initiating educational and informational community events to increase community awareness about prescription drug and opioid misuse and abuse.

**7. Analysis of Evidence-Based Practices (\$35,000)**

Contract with Washington State University to conduct analysis of current selection of evidence-based practice with outcomes in the most salient factors related to youth misuse and abuse of prescriptions drugs to include opiates to be used in implementation of prevention services.

**8. Community Enhancement Grants (\$300,000)**

Utilize application process to fund services to 10-15 communities in Washington State to implement evidence-based programs and drug take back and educational strategies over the course of one-year with the goal of reducing or preventing prescription medicine and opiate misuse and abuse.

**9. Naloxone Distribution (\$200,000)**

WA-Opioid STR funding provides naloxone to vulnerable and underserved populations in partnership with ADAI by providing naloxone to places at both high relative risk (in terms of the local opioid overdose mortality rate) and high absolute risk (in terms of the total number of fatal overdoses and estimated heroin using population).

**Treatment**

**1. Hub and Spoke (\$4,995,950 + \$1,246,247 year 1 carryover = \$ 6,242,197 total)**

DBHR has expanded access for statewide access to Medication Assisted Treatment (MAT) and reduced unmet need by developing and implementing a six (6) hub and spoke 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 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.

**2. Mobile OTP Van (\$400,000)**

Funding will be provided to Evergreen Treatment Services to purchase, customize, and deploy two mobile vans for Opioid treatment, one will be targeted in rural communities and the other will be used to expand services in urban areas.

**3. Low-Barrier Buprenorphine Pilot (\$130,000)**

WA-Opioid STR together with ADAI will develop a low-barrier buprenorphine model to induce and stabilize highly vulnerable people with OUD on buprenorphine at the Seattle Indian Health Board. People will be provided buprenorphine quickly, typically within 1-48 hours, then will receive flexible dosing/prescribing so that they are able to stabilize over 30-60 days. They will be provided ongoing support of a nurse care manager and transitioned to maintenance at a community based health clinic.

**4. PathFinder Peer Project (\$1,660,000)**

PathFinder Peer Project will build on the already established DBHR Projects for Assistance in Transition from Homelessness (PATH) program to provide SUD peers recovery support in two environments, emergency rooms and homeless encampments. The project will link the individuals to needed MAT services and assist in navigating systems and addressing barriers to independence and recovery.

**5. Tribal Treatment (\$240,000)**

WA-Opioid STR funding will be used to add treatment training tracks to currently established tribal conferences, provide funding for tribal participants to attend the conferences. Funding will also be used to create and distribute a media campaigns for tribes to build awareness related to MAT/OUD treatment options for Native Americans.

**6. Treatment Payment Assistance (\$242,524)**

Each of the 10 Regional Service Areas will receive funding to off-set the cost of providing treatment services to opioid use disorder patients who have financial barriers to treatment access. This funding is intended to offset deductible and co-pays for patients seeking treatment for OUD services but are unable to meet co-pay requirements.

**7. OUD Treatment Decision Re-entry Services & COORP (\$690,500)**

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 located 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 MAT services in the county of their release, and expedites their enrollment in a Medicaid health plan.

**8. Bridge to Recovery (JRA) (\$201,000 - Year one was reduced by \$16,750 to \$167,500 due to late start of project)**

Develop an evidenced-based Juvenile Rehabilitation model that reduces substance abuse disorders, increases education and employment opportunities for youth and addresses systemic barriers that perpetuate the cycle, and implement ACRA reentry transition activities that link youth to mainstream services.



**9. Prescription Monitoring Program (\$250,000)**

WA-Opioid STR funding together with the Department of Health (DOH) will support PMP staffing in creating prescriber feedback reports to assist individual providers and provider groups in reviewing their prescribing practices. PMP data will also be provided to DBHR prevention data as an integral part of the developing data books in the development of the CPWI sites and other local substance use disorder planning efforts.

*The Washington State Opioid Response Grant (SOR)*

September 30, 2018 through September 29, 2020.

The Washington State allocation is \$32,834,248 per year/Two year grant. This grant includes 23 projects – 10 prevention, 10 treatment, and 4 recovery support services.

- Prevention \$6,657,237
- Treatment \$18,983,369
- Recovery Support Services Projects \$5,473,300

**Prevention**

**1. Community Prevention and Wellness Initiative (CPWI) Expansion (\$3,769,618) – P1 (opioid response plan strategy 1.1)**

DBHR has identified the next highest-need and currently non-funded communities across the state to become sub-recipient CPWI sites through a competitive application process, conducted in October 2018. The substance consumption and consequence indicators are each summarized into composite risk scores, using a process to standardize diverse indicators, including consumption, consequences associated with consumption (crime, truancy, lack of school success), and socio-economic data for each community. The new communities are scattered across the state, all of which were selected based on a demonstrated need for substance abuse prevention services combined with the readiness to implement strategies to address this need. These communities vary considerably in demographics, locations, and history, but in the selection process they all demonstrated a high level of need, coupled with a readiness and willingness to invest in community-driven and evidence-based strategies and solutions.

In addition RDA will produce Data Books needed by the CPWI-STR Sites; Data Books will include community performance data, risk ranking, risk profiles focusing on prescription drug/opioid indicators needed for community assessment, strategic planning community education, and monitoring of outcomes. Includes Technical Assistance to CPWI Communities, as well as contracting with Washington Technology Solutions (WaTech) \$2,250 – The Athena Forum Excellence in Prevention (EIP) Improvements. The purpose of this project is to improve the functionality of the EIP web page. The Athena Forum is a professional development and training website for prevention professionals. The EIP page provides detailed information on evidence-based substance use prevention programs/strategies including those shown to be effective at reducing youth opioid and/or prescription drug misuse and/or associated risk factors.

**2. Fellowship Program (\$400,000)**

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, and build capacity within high-needs communities to implement prevention services. Interviews were conducted with potential Fellows from WSU who were all graduating this semester. Three candidates were selected to be a part of the Cohort 1 Fellows and started on January 2, 2019. 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.

**3. Community Enhancement Grants (\$800,000) – P2 (opioid response plan strategy 1.5)**

DBHR identified the next high-need communities across the state to become sub-recipient community-based organization (CBO) grantees through a competitive application process, conducted in October 2018. The goal of the CBO grants are to provide direct prevention services to high-need communities. Several CBOs were selected and are implementing services, which may include implementing the direct service program(s) or the statewide Starts with One opioid prevention campaign. Each community is required to participate in the National Prescription Drug Take-Back Days in April and October of each year.

**4. Prescriber Education Training Courses (\$210,000) – P3 (opioid response plan strategy 1.2)**

DBHR is currently planning the development of e-learning courses for WA healthcare providers on opioid prescribing practices for pain in partnership with the University of Washington, Labor and Industries, Bree Collaborative, and Department of Health. Trainings and e-courses will continue to be made available after the SOR funding period. DBHR will also focus on two (one east side and one west side of the State) symposium events for Washington State dental prescribers and oral health care providers who commonly treat youth and adults with injuries and acute pain. The events focus on opioid prescribing practices and guidelines. Contract with Washington State University (WSU), University of Nevada, Reno (UNR), or Washington State Labor and Industries (L&I).

**5. Opioid Summit (\$200,000) – P4 (opioid response plan strategy 1.4, 2.3)**

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 in an effort to reduce opioid use disorder. The Summit will be held in partnership with Idaho, Alaska, and Oregon. This will be held in August 6-9, 2019 in Vancouver, WA. 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 putting together a broader planning group and individual subgroups at this time 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.

**6. Public Education Campaign** (\$1,313,165) – P5 (opioid response plan strategy 1.4)

Enhancement and evaluation of the statewide Starts with One campaign. The contract with DBHR's media vendor, DH, has been amended to include the enhancement, implementation, and evaluation of the statewide Starts with One public education campaign to reach more high-need communities with intentional prevention messaging. DBHR held a meeting at the end of January to plan for the additional funding and activities for the Starts with One campaign. DH is submitting a proposal to HCA/DBHR this month to update the contract. Work with Desautel Hege (DH) and additional media vendors, as needed to design, test and disseminate various public education (cable, radio, newsprint, and social media) messages that promote public education with communities and tribes to meet community needs.

**7. Naloxone Distribution Program** (\$258,835) – P6 (opioid response plan strategy 3.1)

Contract with Department of Health to support the statewide naloxone distribution coordination. There will be tobacco cessation activities in the Opioid Treatment Networks (OTNs) through the new State Opioid Response (SOR) Grant. We will have approximately 17 contractors, and the Department of Health will be providing technical assistance to them.

**8. UW TelePain** (\$40,619)

Provide partial funding to UW for a weekly TelePain program that provides access to a multidisciplinary panel of experts that 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.

**9. Safe Storage Curricula and Training** (\$25,000)

Innovative pilot project to integrate prescription drug misuse and abuse prevention education into existing state services that parents and caregivers receive. This project engage state agencies to submit project proposals up to \$10,000 to establish internal capacity to provide prescription misuse/abuse prevention education and messaging.

**10. Prevention Workforce Enhancements** (\$40,000)

Enhance funding support to the annual Washington State Prevention Summit and Spring Youth Forum. This support will increase the availability of educational opportunities for youth and prevention professionals (and related fields) by providing presentations and workshops geared toward opioid misuse and abuse prevention. Contract with UNR for conference logistics.

## Treatment

**1. Opioid Treatment Networks** (\$7,650,000 + \$221,000 = \$7,871,000) – T1 (opioid response plan strategy 2.2)

DBHR has contracted with 17 organizations (consisting of 8 emergency departments, 5 jails, 2 syringe exchanges, 1 shelter, and 1 fire department) to create Opioid Treatment Networks (OTNs) to provide: Medication Assisted Treatment (MAT) to individuals with opioid use disorder (OUD); funding to build OTN infrastructure; funding for staff; funding for MAT

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 in order 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. The majority of OTNs have executed their contracts, and many have already inducted individuals onto MAT. The data analysts have distributed participant logs to the OTNs and the first completed logs are due back February 11, 2019. \$221,000 moved from DOH tobacco cessation to pay contractors directly for tobacco cessation deliverables.

- 2. OTN TA/Training (\$550,000) – 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. ADAI will also provide support to DSHS Juvenile Rehabilitation for the development of an OTN (\$50,000).
- 3. MAT Treatment Assistance (\$500,000) – T3 (opioid response plan strategy 2.2)**  
DBHR is entering into contracts with Behavioral Health Organizations, Managed Care Organizations, Administrative Service Organizations, and providers in all 10 regions of the state to increase access to MAT services for underinsured and uninsured, clients. This is a required component of the SOR FOA and enhances funding already provided by the STR Grant.
- 4. OTN Tobacco Cessation (\$700,000-\$221,000 to T1 = \$479,000) – T4**  
DBHR is entering into a contract with the Department of Health (DOH) to provide services for OTNs and OTN clients, including WA Tobacco Quitline services, such as phone counseling and nicotine replacement therapy, Tobacco Treatment Specialist (TTS) training for OTN staff and training for providers on cross-addiction, and Quitline referrals processes. \$221,000 transferred to OTNs directly for tobacco cessation deliverable.
- 5. Grant to Tribal Communities (\$464,000) – T5 (opioid response plan strategy 1.1)**  
Tribal prevention and treatment grants to 13 tribes (\$346,000) 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).
- 6. OUD Treatment Decision Re-entry Services & COORP (\$2,671,852) – 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 located 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 MAT services in the county of their release, and expedites their enrollment in a Medicaid health plan.
- 7. WSU Contracted Services (\$521,557) – T7**

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 Tribal Media Liaison to manage Tribal media environment.

**8. Hub & Spoke (\$5,595,950)**

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.

Additionally each hub will also be provided a Data Collection Coordinator (\$100,000 each hub) to ensure SOR GPRA is completed. Current funding is based on STR grant, \$789,825 per Hub & Spoke network. Total per network with additional position \$889,825 x 6= \$5,338,950.

Technical assistance provided by the University of Washington, ADAI (Alcohol & Drug Abuse Institute) \$257,000. Total Cost: \$5,595,950

**9. Low-Barrier Buprenorphine Pilot (\$130,000)**

ADAI together with the Seattle Indian Health Board, provide a low-barrier MAT clinic to stabilize highly vulnerable people with Opioid Use Disorder (OUD) on buprenorphine in a community based setting. People are provided services quickly, typically within 24-hours, and receive flexible dosing/prescribing so that they are able to stabilize over 30-60 days. They are provided ongoing nurse care manager support and transitioned to maintenance at a community based health clinic. The goal of the project is to provide low barrier access to highly vulnerable, often homeless urban American Indian, Alaskan Native individuals.

**10. Tribal Treatment (\$200,010)**

Tribal Treatment provides funding to add MAT treatment training tracks to currently established tribal conferences, and provide funding for tribal participants to attend the conferences (\$60,000). Create and distribute media campaigns for tribes to build awareness related to MAT/OUD treatment options for Native Americans (\$140,010). The goal of the project is to work collaboratively with recognized tribal governments to engage in MAT services.

**Recovery**

**1. OUD and MAT Training to Community Recovery Support Services (\$15,000) – R1 (opioid response plan strategy 2.2.5)**



TA/training will be provided to staff at: Catholic Community Services in Burlington, Everett Recovery Café, Seattle Recovery Café, Peer Seattle/Seattle Area Support Groups, Tacoma Recovery Café, and Comprehensive Healthcare in Walla Walla, Okanogan Behavioral Healthcare, Spokane Recovery Café and Vancouver Recovery Café. Recovery Support Staff will be provided scholarships and training costs to attend the Region X Opioid Symposium in August 2019.

2. **Client-directed Recovery Support Services** (\$2,750,000) – R2 (opioid response plan strategy 2.2.5)  
Contracted direct recovery support services to Catholic Community Services in Burlington, Everett Recovery Café, Seattle Recovery Café, Peer Seattle/Seattle Area Support Groups, Tacoma Recovery Café, Comprehensive Healthcare in Walla Walla, Okanogan Behavioral Healthcare, Spokane Recovery Café and Vancouver Recovery Café.
3. **Peer Recovery Support** (\$1,085,000) – R3 (opioid response plan strategy 2.2.5)  
Contracted peer recovery staff for: Catholic Community Services in Burlington, Everett Recovery Café, Seattle Recovery Café, Peer Seattle/Seattle Area Support Groups, Tacoma Recovery Café, Comprehensive Healthcare in Walla Walla, Okanogan Behavioral Healthcare, Spokane Recovery Café and Vancouver Recovery Café.
4. **PathFinder Peer Project** (\$1,623,300)  
Description: PathFinder Peer Project builds on the already established DBHR Projects for Assistance in Transition from Homelessness (PATH) program to provide substance use disorder (SUD) peer recovery support in two environments, emergency rooms and homeless encampments. The project links individuals to needed MAT services and assist in navigating systems and addressing barriers to independence and recovery. The goal of the project is to provide SUD peers in environments with high populations of individuals with OUD.

*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

Naloxone distribution to 5 High Need Areas (HNA) across Washington State. Each HNA includes multiple counties.

Year 1: (January 2017 to August 2017)

Individuals Trained:	426
Naloxone Kits Distributed:	2,728 (includes refills)
Overdose Reversals:	389



Year 2: (September 2017 to August 2018)

Individuals Trained:	1,118
Naloxone Kits Distributed:	9,227 (includes refills)
Overdose Reversals:	1,538

Year 3: (Partial Year - September 2018 to March 2019)

Individuals Trained:	1,058
Naloxone Kits Distributed:	7,391 (includes refills)
Overdose Reversals:	1,419

This grant continues through August 31, 2021.

The Prescription Drug and Opioid Addiction Project (WA-MAT-PDOA) will expand access to integrated medication assisted treatment (MAT) with buprenorphine for individuals with an opioid addiction. A proven office-based opioid treatment (OBT) model is in both a large urban safety-net primary care clinic and two opioid treatment program sites who serve predominately rural populations. The WA-MAT-PDOA is a collaborative effort between state agencies, Harborview Medical Center, and Evergreen Treatment Services to address the rising rates of opioid-related problems in Washington.

*Washington State Department of Health (DOH)*

December 1, 2018 through September 30, 2019 (\$864,000)

Funding from the SABG is allocated for naloxone distribution and training. This is part of the sustainability plan to continue naloxone distribution statewide after the WA-PDO grant ends 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.

Implementation of Secure Withdrawal Management and Stabilization Facilities

The 2016 Legislative Session, House Bill 1713 directed DBHR to create Secure Withdrawal Management and Stabilization Facilities and made changes to multiple aspects of the behavioral health system. Effective April 1, 2018, the bill amends RCW 71.05 and 71.34 to align the substance use involuntary Treatment process with the existing mental health ITA process.

DBHR created a 16 hour training program for all DMHPs on substance use disorders processes and petitioning for initial detention of SUD into the mental health detention process. All DMHPs have taken the training provided by HCA.

The bill directs the department to create a sixteen-bed secure detoxification facility to be operational by April 1, 2018. It further directs the department to create one additional facility per year until there is a total of nine facilities statewide.

On April 1, 2018 two adult facilities opened as scheduled and are currently providing withdrawal management services, American Behavioral Health Services (ABHS) Chehalis (21) beds and American

Behavioral Health Services (ABHS) Spokane (24) beds. The Health Care Authority, Division of Behavioral Health and Recovery expects to have facility capacity options available within the timelines established in HB 1713.

These facilities are licensed as a Secure Withdrawal Management and Stabilization facility (SWMS), certified by Department of Health (DOH) to provide services American Society of Addiction Medicine (ASAM) 3.7 Withdrawal Management services. These facilities provide up to 17 days of withdrawal management and stabilizing care to individuals who present a likelihood of serious harm to themselves or others, other's property, or are gravely disabled due to a substance use disorders (SUD). Individuals in need of (SUD) treatment longer than seventeen days may receive outpatient or residential treatment voluntarily, or on a less restrictive alternative court orders.

### 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 is 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. The hope was that Department of Health would pick up the task of a co-occurring WAC for services as well as for credentialing of staff.

## 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 M/SUD system 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 M/SUD system. Especially for those required populations described in this*

*document and 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.*

*A data-driven process must support the state's priorities and goals. This could include data and information that are available through the state's unique data system (including community-level data), as well as SAMHSA's data sets including, but not limited to, the National Survey on Drug Use and Health (NSDUH), the Treatment Episode Data Set (TEDS), the National Facilities Surveys on Drug Abuse and Mental Health Services, and the Uniform Reporting System (URS). 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 should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, substance use disorder prevention, and SUD treatment goals at the state level. In addition, states should obtain and include in their data sources information from other state agencies that provide or purchase M/SUD services. This will allow states to have a more comprehensive approach to identifying the number of individuals that are receiving services and the types of services they are receiving.*

*In addition to in-state data, SAMHSA has identified several other data sets that are available to states through various federal agencies: CMS, the Agency for Healthcare Research and Quality (AHRQ), and others.*

*Through the Healthy People Initiative HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.*

## WASHINGTON STATE NEEDS ASSESSMENT

Washington State integrated substance abuse and mental health purchasing in April 2016 and is in the process of moving to integrated care with primary health by January 2020. As of July 2019, Washington has seven regions that have integrated, with the remaining three regions expected to be integrated by January 1, 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 American Indian (AI)/Alaska Native (AN) population, who will have the option of receiving mental health and substance use disorder treatment through the Medicaid managed care system or through a fee-for-service delivery system. The state will continue to maintain the TARGET System for data collection from the fee-for-service system.

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 DBHR's 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 and treatment planning. The SEOW is currently housed in DBHR and is co-chaired by the DBHR SUD Prevention and MH Promotion Section Manager and leadership at the Department Health (DOH). Members of SEOW include epidemiologists from multiple state agencies and universities tasked with monitoring and improving the behavioral health of the population. 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 developed and biennially updates the Prevention Needs Assessment for the Strategic Prevention Enhancement Consortium Strategic Plan.

### Strategy to Identify Unmet Needs and Gaps

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 status among in-school adolescents, as well as risk factors that predict poor behavioral health outcomes. The survey, supported by four state agencies and administered every two years 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 even school building levels. The last HYS was conducted in the fall of 2018 which provided data for DBHR's needs assessment, including broadening surveillance capacity for LGBTQ communities, teen anxiety and substance use issues related to vapor products.

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 marijuana 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, filling these gaps with a larger sample to allow for comparison of sub-populations, and detailed questions that enable assessment of how substance use patterns are changing among young adults in the state. Moving forward, 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.

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 programs and strategies on the list 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.

For specific priority subpopulations, including pregnant injecting drug users, pregnant substance abusers, injecting drug users, 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 pregnant substance users. 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 assessment. The CORE Geographic Information System (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.

#### *Behavioral Health Data Store (BHDS)*

Washington State is in the transition phase of successfully integrating behavioral health services, which includes mental health (MH) and substance use disorder (SUD) treatment, into the primary medical service system. This phased approach to transitioning the Behavioral Health Organizations (BHO) into Integrated Managed Care (IMC) will be fully implemented by the July 2020.

Washington State has also collaborated on transitioning staff and data resources from a BHO model to an IMC model. This involved the move of the Division of Behavioral Health and Recovery from the Department of Social and Health Services (DSHS) to the Health Care Authority (HCA). As part of this transition, multiple workgroups and steering committees were established to ensure coverage for all the transition needs. These needs included, but were not limited to plans for database transfers; access and firewall adjustments; requirement reporting tasks allocated to appropriate resources; and staff relocation planning. One of the main data sources that was in scope for the transition project was the Behavioral Health Data Store (BHDS).

The BHDS is the data system that replaced the MH-CIS data system, and most of the TARGET data system, starting in April 2016. The BHDS stores both MH and SUD data to support various programs throughout integrated HCA. With the movement from the BHO model to the IMC model, the providers and billing agencies are also accommodating a change in their systems and processes. For the BHO regions still not yet fully transitioned, the report and submission requirements have not changed. Those BHOs continue to submit HIPAA-level claim transactional data, as well as the non-claim transactional data to support the additional fields within the BHDS, to support SAMSHA reporting and other state-required reporting. For the IMC regions, the claim submissions to HCA's ProviderOne claims system have been limited due to the clarifications needed around submission requirements for the MH and SUD data. A workgroup was generated, called the Behavioral Health Reporting and Data Standardization workgroup (BRADS), to develop a long-term data solution that

- Supports SAMHSA block grant reporting requirements;
- Supports and other necessary state reporting needs; and
- Standardizes the native data collection process as part of an approved SAMHSA Corrective Action Plan (CAP).

The BRADS workgroup is reviewing both the ability of the Managed Care Organization (MCO) and BH-ASO to collect data for submission to the State and the administrative burden on the behavioral health



provider community. The BRADS workgroup is diligently working with a contracted vendor, Milliman, to review the needs assessment and gaps in the data.

As a result of the BRADS workgroup's findings, there are a number of modifications and significant system and reporting changes that need to take place in order for Washington State to have consistent and high quality data for its required reporting.

To ensure all entities are reporting accurate and consistent data, the BRADS workgroup is going to move forward with modifying the BHDS to better meet the needs of SAMSHA reporting, as well as state reporting requirements. These BHDS enhancements involve a number of contract changes, system changes, and reporting logic changes. This change effort will increase the quality of the data being reported, will provide clarity to the IMC regions and the provider community, and will allow for the BH transition project from DSHS to HCA to be fully executed.

#### 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 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.

Using a data-based approach, the Washington State Prevention Enhancement Policy Consortium (SPE) is developing an update to the state's Substance Abuse Prevention and Mental Health Promotion Strategic Plan, projected to be completed in Fall 2019. The current State of Washington Substance Abuse and Mental Health Promotion Five-Year Strategic Plan was developed in 2012. It was updated in 2015 and 2017, and both past plans and the current plan are posted at [www.TheAthenaForum.org/spe](http://www.TheAthenaForum.org/spe). The Consortium is comprised of representatives from 26 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 abuse prevention programming, mental health promotion programming, and programming for related issues.

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. The SEOW identifies highest-need communities through a risk ranking that integrates data on prevalence of and consequences related to substance use; separate rankings were developed for underage drinking, marijuana use, opioid use, and all ATOD use. Using the most recent data, SEOW periodically updates the risk rankings. The most recent update was in spring 2019. Because the HYS and CORE data are 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.

An important aspect of DBHR's surveillance work is providing increasingly sophisticated access to data for our program managers, BHOs, and other providers. DBHR has created the System for Communicating Outcomes, Performance & Evaluation (SCOPE) <http://www.scopewa.net>, a web-based mental health and substance abuse reporting system. It consists of two broad functions: 1) standard reports, which typically address issues of general interest to constituents in pre-formatted output and 2) an ad hoc query function that allows users to perform analyses and data summaries using a drop-down menu interface. Improvements made to the SCOPE system design in 2017 will integrate data from the new Behavioral Health Data System. This redesign will result in a user interface that better corresponds with administrative changes, as well as extensive modification to existing reports and creation of new reports to improve information provided to SCOPE users. The new system will be available for the BHOs, program managers, legislative staff and other stakeholders.

### Prioritize State Planning Activities

#### Priorities

##### **Priority 1: 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 2: Increase the number of youth receiving outpatient substance use disorder treatment.**

##### **Priority 8: Increase the number of adults receiving outpatient substance use disorder treatment.**

Issues around access, service timeliness, and penetration continue to be a focus of substance use disorder treatment services as the state moves to 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 3: Increase the number of SUD Certified Peers.**

DBHR 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 4: Increase outpatient mental health services for youth with SED.**

##### **Priority 6: Increase 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 5: Increase capacity for early identification and intervention for individuals experiencing First Episode Psychosis.**

DBHR is committed to increasing the number of mental health community based agencies who serve youth diagnosed with First Episode Psychosis.

**Priority 7: Increase the number of individuals receiving recovery support services, including increasing employment services and decreasing homelessness for individuals with SMI, SED and SUD.**

DBHR 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.

**Priority 9: Pregnant and Parenting Women with Dependent Children.**

Pregnant and parenting women continue to be a priority population for substance use disorder services to improve their health and assist in maintaining recovery.

**Priority 10: Maintain Government to Government relationships with Tribal Governments.**

American Indians/Alaska Natives continue to be a priority for substance use disorder services. The SABG funding that the tribes receive remains at the same level.

Development of Goals, Objectives, Performance Indicators and Strategies

Planning Table #1: Priority Areas and Annual Performance Indicators

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*Priority #: 1*

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

**Priority Type:** SAP

**Population(s):** PP, Other (Adolescents w/SUD and/or MH, Rural, Asian, Tribal communities, Native Hawaiian/Other Pacific Islanders, Underserved Racial and Ethnic Minorities)

**Goal of the priority area:**

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

**Objective:**

- Decrease the percentage of 10th graders who report using alcohol in the last 30 days (HYS 2018: 18.5%; Target 2023: 18%).
- Prevent the increase in the percentage of 10th graders who report using marijuana in the last 30 days (HYS 2018: 17.9%, Target 2023: 15.3%).
- Decrease the percentage of 10th graders who report using tobacco products in the last 30 days (HYS 2018 Tobacco, any form except vape: 7.6%, Target 2023: 9.2%; HYS 2018 Tobacco – vape: 21.2%, Target 2023: 11.4%).
- Decrease the percentage of 10th graders who report misusing/abusing painkillers in the past 30 days (HYS 2018: 6.8%, Target 2023: 4.0%).

**Strategies to attain the objective:**

- Implement performance-based contracting with each prevention contractor.
- Adapt programs to address the unique needs of each tribe.
- Deliver Evidenced-based Prevention Programs and Strategies according to approved strategic plans.
- Deliver direct prevention services.
- Deliver community-based prevention services (Environmental).
- Provide statewide Workforce Development Training to build capacity for service delivery.
- Develop innovative strategies to target underserved populations such as AI/AN and Tribal groups.

**Annual Performance Indicators to Measure Goal Success**

**Indicator #: 1**

**Indicator:** Reduce substance use/misuse

**Baseline Measurement:** 18,042 unduplicated direct services provided based during SFY 2018 (July 1, 2017 – June 30, 2018)

**First-year target/outcome measurement:** Maintain or increase number of prevention programs and participants compared to the SFY18 baseline (July 1, 2017 – June 30, 2018) of 18,042 unduplicated direct services

**Second-year target/outcome measurement:** Maintain or increased number of prevention programs and participants compared to the SFY18 baseline (July 1, 2017 – June 30, 2018) of 18,042 unduplicated direct services

**Data Source:**

Washington's Management Information Service (SUD Prevention and MH Promotion Online Reporting System): used to report SABG performance indicators.

Washington State Healthy Youth Survey (HYS): used to report 30 day 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.

**Data issues/caveats that affect outcome measures:**

Data integrity is 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.

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*Priority #: 2*

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

**Priority Type:** SAT

**Population(s):** PWWD, PWID, Other (Adolescents w/SA and/or MH, LGBTQ, Rural, Criminal/Juvenile Justice, Children/Youth at Risk for BH Disorder, Youth Experiencing Homeless, Asian, tribal communities, Native Hawaiian/Other Pacific Islanders, Underserved Racial and Ethnic Minorities)

**Goal of the priority area:**

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

**Objective:**

- Require Behavioral Health Organizations (BHOs) and Managed Care Organizations (MCOs) to continue to maintain behavioral health provider network adequacy for adolescents.
- Re-examine current adolescent network and capacity
- Improve access and increase available SUD outpatient services for youth.

**Strategies to attain the objective:**

- 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 BHOs and MCOs to ensure focus and oversight of provider network.

**Annual Performance Indicators to Measure Goal Success**

**Indicator #: 1**

**Indicator:** Increase youth outpatient SUD treatment services

**Baseline Measurement:** SFY18: 3,484 youth received SUD outpatient treatment services

**First-year target/outcome measurement:** Increase the number of youth receiving SUD outpatient treatment services in SFY20 to 3,584

**Second-year target/outcome measurement:** Increase the number of youth receiving SUD outpatient treatment services in SFY21 to 3,684

**Data Source:**

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

**Description of Data:**

The calendar year 2016 data is an unduplicated count of youth (persons under 18 years of age) served in publically-funded SUD outpatient treatment between January 1, 2017, and December 31, 2018.

**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. Indian Health Care Providers have to enter data into multiple systems which can be burdensome.

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*Priority #: 3*

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**Priority Area:** Increase the number of SUD Certified Peers

**Priority Type:** SAT

**Population(s):** PWWDC, PWID, TB, Other (Adolescents w/SA and/or MH, Students in College, LGBTQ, Children/Youth at Risk for BH Disorder, Homeless, Asian, Tribal communities, Native Hawaiian/Other Pacific Islanders, Underserved Racial and Ethnic Minorities)

**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

**Objective:**



- Pilot SUD peers
- Develop a strategic plan to review curriculum, funding strategies and rule changes

**Strategies to attain the objective:**

- BHA/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

**Annual Performance Indicators to measure goal success**

**Indicator #: 1**

**Indicator:** SUD peer support program

**Baseline Measurement:** From July 1, 2018 – June 30, 2019 total number of SUD trained peers was 200

**First-year target/outcome measurement:** Peer support program in SFY20 that would train 280 peers

**Second-year target/outcome measurement:** Peer support program in SFY21 that would train 350 peers

**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.

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*Priority #: 4*

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**Priority Area:** Increase outpatient mental health services for youth with SED

**Priority Type:** MHS

**Population(s):** SED

**Goal of the priority area:**

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

**Objective:**

- Require the Behavioral Health Organizations (BHOs) and I/T/U to improve and enhance available behavioral health services to youth.

**Strategies to attain the objective:**

- Require BHOs to maintain behavioral health provider network adequacy.
- Increase available MH community-based behavioral health services for youth diagnosed with SED.

**Annual Performance Indicators to measure goal success**

**Indicator #: 1**

**Indicator:** Increase outpatient MH services to youth with SED

**Baseline Measurement:** SFY18: 40,319 youth with SED received services

**First-year target/outcome measurement:** Increase the number of youth with SED receiving outpatient services to 40,820

**Second-year target/outcome measurement:** Increase the number of youth with SED receiving outpatient services 41,320

**Data Source:**

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

**Description of Data:**

Fiscal Year 2018 is an unduplicated count of youth with SED who under the age of 18 served in publically funded outpatient mental health programs from July 1, 2017 through June 30, 2018.

**Data issues/caveats that affect outcome measures:**

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

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*Priority #: 5*

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**Priority Area:** Increase capacity for early identification and intervention for individuals experiencing First Episode Psychosis.

**Priority Type:** MHS

**Population(s):** SED/SMI

**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).

**Objective:**

- Increase capacity in the community to serve youth experiencing FEP

**Strategies to attain the objective:**

- Provide funding to increase the number of agencies who serve youth with FEP.
- Increase available MH community based behavioral health services for youth diagnosed with FEP.

**Annual Performance Indicators to measure goal success**

**Indicator #: 1**

**Indicator:** Increase outpatient MH capacity for youth with FEP.

**Baseline Measurement:** SFY18: 6 sites serving 125 youth

**First-year target/outcome measurement:** Increase the number of coordinated specialty care sites from 5 to 9 serving an additional 100 youth statewide.

**Second-year target/outcome measurement:** Increase the number of coordinated specialty care sites from 9 to 12 serving an additional 75 youth statewide.

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*Priority #: 6*

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**Priority Area:** Increase the number of adults with SMI receiving mental health outpatient treatment services

**Priority Type:** MHS

**Population(s):** SMI, Other (LGBTQ, Homeless, Asian, Tribal communities, Native Hawaiian/Other Pacific Islanders, Underserved Racial and Ethnic Minorities)

**Goal of the priority area:**

Increase the number of adults with SMI accessing mental health outpatient services.

**Objective:**

- Require MCOs, BHASOs, and BHOs to maintain and enhance behavioral health provider network adequacy.

- Increase available mental health behavioral health services for adults.

**Strategies to attain the objective:**

- Convene Medicaid enrollment workgroup to determine best practices for enrollment at point of first contact.
- Gather data and resources regarding how potential individuals are identified.

**Annual Performance Indicators to Measure Goal Success**

**Indicator #: 1**

**Indicator:** Increase mental health outpatient services for adults with SMI

**Baseline Measurement:** SFY18: 103,208 adults with SMI received mental health outpatient services

**First-year target/outcome measurement:** Increase the number of adults with SMI in SFY18 to 103,668

**Second-year target/outcome measurement:** Increase the number of adults with SMI in SFY19 to 104,128

**Data Source:**

The number of adults with SMI receiving MH outpatient treatment services is tracked using the Behavioral Health Administration (BHA) Behavioral Health Data System (BHDS).

**Description of Data:**

Fiscal Year 2018 clients served is an unduplicated count of adults with SMI (persons 18 years of age and older) served in publically funded mental health outpatient programs between July 1, 2017 and June 30, 2018.

**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.

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*Priority #: 7*

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**Priority Area:** Increase the number of individuals receiving recovery support services, including increasing employment services and decreasing homelessness for individuals with SMI, SED, and SUD

**Priority Type:** SAT, MHS

**Population(s):** SMI, SED, PWWDC, PWID, TB, Other (Homeless, Asian, Tribal communities, Native Hawaiian/Other Pacific Islanders, Underserved Racial and Ethnic Minorities)

**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. Number and percent of individuals with any earnings in the quarter of services, homelessness/housing instability using the broad measure of homelessness.

**Objective:**

- Increase awareness, implementation and adherence to the evidence-based practices of permanent supportive housing and supported employment models by implementing fidelity reviews at five agencies

**Strategies to attain the objective:**

- Train 500 staff working in behavioral health, housing and health care, through webinars or in-person training events
- Assist 300 individuals exiting or at risk of entering inpatient behavioral health settings with housing supports
- Assist 300 individuals to obtain 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 employment services

**Baseline Measurement:** FY2018 - 23,133

**First-year target/outcome measurement:** Increase employment by 5% in FY20 (additional 1,156)

**Second-year target/outcome measurement:** Increase employment by 5% in FY21 (additional 1,214)

**Data Source:**

Washington State Employment Security Department (ESD)

**Description of Data:**

Includes all members with at least one quarter in the measurement year with positive earnings recorded in the ESD quarterly wage data. Note that ESD reported earnings data does not include self-employment, federal employment, or unreported earnings.

**Data issues/caveats that affect outcome measures:**

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

**Indicator #: 2**

**Indicator:** Decrease homelessness

**Baseline Measurement:** FY2018 - 16,168

**First-year target/outcome measurement:** Decrease by 5% (808 fewer)

**Second-year target/outcome measurement:** Decrease by 5% (768 fewer)

**Data Source:**

ACES (DSHS Medicaid Eligibility System), Homeless Management Information System (HMIS) and the Behavioral Health Data Systems (BHDS).

**Description of Data:**

Include all denominator-eligible members with at least one month with a living arrangement status of "Homeless with Housing", "Homeless without Housing", "Emergency Shelter" or "Battered Spouse Shelter" recorded in the ACES eligibility data system.

**Data issues/caveats that affect outcome measures:**

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

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*Priority #: 8*

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

**Priority Type:** SAT

**Population(s):** PWWDC, PWID, TB, Other (LGBTQ, Criminal/Juvenile Justice, Homeless, Asian, Tribal communities, Native Hawaiian/Other Pacific Islanders, Underserved Racial and Ethnic Minorities)

**Goal of the priority area:**

Increase the number of adults receiving outpatient SUD treatment including adults who are using opioids and other prescription drugs.

**Objective:**

- Require the Behavioral Health Organizations (BHOs) to improve and enhance available SUD outpatient services to adults.

**Strategies to attain the objective:**

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

**Annual Performance Indicators to Measure Goal Success**

**Indicator #:** 1

**Indicator:** Increase outpatient SUD for adults in need of SUD treatment

**Baseline Measurement:** SFY18: 46,852

**First-year target/outcome measurement:** Increase the number of adults in SFY20 to 47,875



**Second-year target/outcome measurement:** Increase the number of adults in SFY21 to 48,888

**Data Source:**

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

**Description of Data:**

Fiscal Year 2018 is an unduplicated count of adults (persons 18 years of age and older) served in publically-funded SUD outpatient treatment between July 1, 2017 and June 30, 2018.

**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. Indian Health Care Providers have to enter into multiple systems which can be burdensome.

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*Priority #: 9*

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**Priority Area:** Pregnant and Parenting Women with Dependent Children

**Priority Type:** SAT

**Population(s):** PWWDC

**Goal of the priority area:**

Increase the number of PPW clients receiving case management services

**Objective:**

Improve the health of pregnant and parenting women and their children, and help them maintain their recovery.

**Strategies to attain the objective:**

- Increase access to case management services

**Annual Performance Indicators to measure goal success**

**Indicator #: 1**

**Indicator:** Work with the Parent Child Assistance Program (PCAP) providers to ensure that women and their children have access to case management services

**Baseline Measurement:** From June 2018 to December 2018 the average number of PPW clients receiving case management services was 1,262

**First-year target/outcome measurement:** Increase the average number of PPW clients receiving case management services by 5% (average of 1,325 clients)

**Second-year target/outcome measurement:** Maintain the number of PPW clients receiving 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 Fetal Alcohol and Drug Unit (FADU) for monthly reporting

**Data issues/caveats that affect outcome measures:**

If funding is reduced by the Washington State Legislature, the number of sites may decrease, resulting in fewer clients receiving case management services.

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*Priority #: 10*

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**Priority Area:** Maintain Government to Government relationships with Tribal Governments

**Priority Type:** SAP, SAT

**Population(s):** PWWDC, PP, PWID, TB, Other (Underserved Racial and Ethnic Minorities)

**Goal of the priority area:**

Adhere to the Washington State Centennial Accord and DSHS Administrative Policy 7.01 which directs DSHS Administrations to communicate, collaborate, and formally consult with the 29 Federally Recognized Tribes when funding and policy changes will have an impact on Tribal Governments, Urban Indian Health Programs, Recognized American Indian Organizations, and individual American Indians/Alaska Natives. By extension of the Accord and Policy, DBHR gives all 29 Tribes the opportunity to apply for block grant funding to help bolster prevention and treatment services within their tribal communities.

**Objective:**

- Support the Tribes to use block grant funding for the following services for youth and adults who are non-Medicaid and low income: assessments, case management, drug screening tests including urinary analysis, outpatient and intensive outpatient, and individual and group therapy;
- Support the Tribes to use block grant funding to begin and/or maintain tribal substance use disorder prevention programs and projects for youth within tribal communities.

**Strategies to attain the objective:**

- Each tribe is required to complete a Tribal Plan and budget that indicates how the funding will be expended on approved SUD prevention or treatment activities, and DBHR must approve each plan and each update to a Tribal Plan.
- Each tribe must submit quarterly expenditure reports to DBHR.
- Each tribe must input 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.
- DBHR will work in good faith with the Tribes and Urban Indian Health Programs to streamline the data reporting process in the future.
- Each tribe must submit 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.

**Annual Performance Indicators to measure goal success**

**Indicator #: 1**

**Indicator:** Maintain treatment and prevention to American Indian/Alaska Natives

**Baseline Measurement:** Treatment 4,872

**First-year target/outcome measurement:** Treatment 4,872

**Second-year target/outcome measurement:** Treatment 4,872

**Data Source:**

The Substance Use Disorder Prevention and Mental Health Promotion MIS and TARGET, or its successor, for treatment counts.

**Description of Data:**

As reported into TARGET by Tribes, total number of AI/AN clients served between July 1, 2017 and June 30, 2018.

**Data issues/caveats that affect outcome measures:**

Indian Health Care Providers have to enter into multiple systems which is burdensome.

[Environmental Factors and Plan](#)

The Health Care System, Parity and Integration

*Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions. Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but “[h]ealth system factors” such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise,*

*and properly treat such chronic health conditions as diabetes and cardiovascular disease. It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.*

*Currently, 50 states have organizationally consolidated their mental and substance use disorder authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders. SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity. For instance, some organizations have established medical-legal partnerships to assist persons with mental and substance use disorders in meeting their housing, employment, and education needs.*

*Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and M/SUD with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.*

*SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders. The state should illustrate movement towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders. The plan should describe attention to management, funding, payment strategies that foster co-occurring capability for services to individuals and families with co-occurring mental and substance use disorders. Strategies supported by SAMHSA to foster integration of physical and M/SUD include: developing models for inclusion of M/SUD treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between M/SUD providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as Federally Qualified Health Centers; and sharing with consumers information about the full range of health and wellness programs.*

*Health information technology, including EHRs and telehealth are examples of important strategies to promote integrated care. Use of EHRs – in full compliance with applicable legal requirements – may allow providers to share information, coordinate care, and improve billing practices. Telehealth is another important tool that may allow M/SUD prevention, treatment, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time, and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes and ACOs may be important strategies used by SMHAs and SSAs to foster integrated care. Training and assisting M/SUD providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health*

*Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes.*

*SMHAs and SSAs also may work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations. Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.*

*One key population of concern is persons who are dually eligible for Medicare and Medicaid. Roughly, 30 percent of persons who are dually eligible have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible. SMHAs and SSAs also should collaborate with state Medicaid agencies and state insurance commissioners to develop policies to assist those individuals who experience health insurance coverage eligibility changes due to shifts in income and employment. Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with M/SUD conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider. SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of M/SUD conditions and work with partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.*

*SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment. Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists, and others will need to understand integrated care models, concepts, and practices.*

*Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to M/SUD services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. The SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. The SSAs and SMHAs should collaborate with their states' Medicaid authority in ensuring parity within Medicaid programs.*

*SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues.*

*Another key part of integration will be defining performance and outcome measures. The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, which includes information and resources to help promote health, good outcomes, and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.*

*SAMHSA recognizes that certain jurisdictions receiving block grant funds – including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Medicaid provisions or are ineligible to participate in certain programs. However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment, and recovery support for persons with, or at risk of, mental and substance use disorders.*

**Please respond to the following items in order to provide a description of the healthcare system and integration activities:**

**1. Describe how the state integrates mental health and primary health care, including services for individuals with co-occurring mental and substance use disorders, in primary care settings or arrangements to provide primary and specialty care services in community-based mental and substance use disorders settings.**

Washington's Medicaid system is in the process of transitioning from two distinct managed care systems to a 'whole person' system of care whereby the full continuum of physical and behavioral health care is 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. As of July 1, 2019, all but three of the nine regional service areas (RSAs) implemented fully integrated managed care (FIMC). The final three regions will implement FIMC in January 2020.

**2. Describe how the state provide services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, payment strategies that foster co-occurring capability.**

In April 2016, our state's integration efforts were further bolstered by Washington State Department of Social and Health Services (DSHS) integrating the management of the mental health and substance use disorder systems of care. Washington moved from a mental health system managed by Regional Service Networks (RSNs) and a substance use disorder treatment system managed by the counties, to both being managed by managed care entities: Behavioral Health Organizations (BHOs) or Managed Care Organizations (MCOs). The most effective treatment for individuals with dual diagnoses integrates mental health and substance use interventions. This management model provides a better opportunity for supporting individuals with dual diagnoses by working to increase the number of facilities that can provide dual treatment, increasing the number of dually certified providers, and supporting improved care coordination and communication between disciplines. This integrated model will continue as the state moves toward fully integrated care as described in question 1.



The National Survey on Drug Use and Health (NSDUH) 2010/2011 data reports that 75 percent of individuals in Washington State with mental health or substance use disorder conditions also have chronic medical conditions. Fully integrated managed care implemented across the state will position Washington State to provide whole-person care along a continuum of need. As a result of integrating the behavioral health delivery system, the state fully integrated the managed care payments that were provided for mental health services and the fee-for-service payments provided for substance use disorder services into a behavioral health managed care rate. This provides the flexibility for the BHOs and MCOs to provide services across the continuum of substance use and mental health disorders and removes a funding silo. The state continues to review and update state rules and laws, contract language, state plan authority and funding strategies to support more models of co-occurring services. Recent changes include integrating previously separate SUD and MH licensing rules into one behavioral health rule set. This work is being done in partnership with the BHOs, MCOs, providers and other stakeholders with the goal to provide as much clarity and flexibility within our current laws, funding, and state plan to support co-occurring delivery models.

#### Evidence Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI)

*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.*

**1. Does the state have policies for addressing early serious mental illness (ESMI)?**

Yes

**2. Has the state implemented any evidence-based practices (EBPs) for those with ESMI?**

Yes

**If yes, please list the EBPs and provide a description of the programs that the state currently funds to implement evidence-based practices for those with ESMI**

The Mental Health Block Grant (MHBG) 10 percent set aside currently supports five Coordinated Specialty Care (CSC) teams. This includes the initial New Journeys Demonstration Project at Central Washington Comprehensive Mental Health in Yakima, which began in 2015 and subsequent launch of four additional sites including Thurston-Mason and King Counties in 2016, Grays Harbor County in 2017 and Clark County in 2018. The state is also working to launch three additional sites in the second half of 2019. These teams are preparing for launch in the Greater Columbia, North Central and King County areas of the State. All sites receive training, technical assistance and consultation from a team of local and national experts led by Dr. Maria Monroe-DeVita from the University of Washington (UW) Department of Psychiatry and Behavioral Sciences. Dr. Monroe-DeVita is the project director and oversees all aspects of implementation, including program start up, training, ongoing consultation, and coordination and planning between the Demonstration Projects and DBHR. Dr. Monroe-DeVita is joined by her training team at UW, in consultation with national experts from the NAVIGATE program to ensure proper training and fidelity to New Journeys.

**3. How does the state promote the use of evidence-based practices for individuals with ESMI and provide comprehensive individualized treatment or integrated mental and physical health services?**

The state partnered with the Washington Council for Behavioral Health (WCBH) in May 2016 to begin the groundwork to make policy recommendations in the 2017-2019 Biennium. WCBH organized and conducted a policy summit with executive branch policy leaders to increase the understanding and buy-in for a statewide approach to early intervention for psychosis. The summit took place in October 2016 and included a pre-conference symposium that provided updates and data on progress and outcomes for the New Journeys sites. Following the conference, the state worked with WCBH to develop a working draft of a Washington State Policy Statement on Early Psychosis Identification and Intervention

**4. Does the state coordinate across public and private sector entities to coordinate treatment and recovery supports for those with ESMI?**

Yes

**5. Does the state collect data specifically related to ESMI?**

Yes

**6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI?**

Yes

**7. Please provide an updated description of the State's chosen EBPs for the 10 percent set-aside for ESMI.**

Teams, utilizing New Journeys Coordinated Specialty Care Navigate model, are comprised of four to six clinicians with the appropriate expertise. Key roles, in addition to outreach and engagement, include team leadership, case management, supported employment and education, psychotherapy and skills training, family education and support, pharmacotherapy, medication management, co-occurring substance use disorder counseling, peer support and primary care coordination. Supervision and consultation is provided within the context of the recommendations for each role, as directed by the NAVIGATE Consultants and UW.

**8. Please describe the planned activities for FFY 2020 and FFY 2021 for your state's ESMI programs including psychosis?**

The planned activities for FFY 2020 and FFY 2021 are:

- Continued Development of New Journeys Network, overseeing the implementation and training of at least two additional Coordinated Specialty Care New Journeys teams while laying the foundation to have this benefit available statewide.
- Implementation of NAVIGATE Coordinated Specialty Care Training and Consultation for new and existing sites.

All New Journeys Demonstration Projects will implement NAVIGATE as their Coordinated Specialty Care model. Sites are required to attend and participate in all trainings, and participate in monthly consultation calls and ECHO clinic. In addition to participation in training and

consultation, all sites will be encouraged to engage in peer-to-peer learning opportunities throughout the project.

- Evaluation and data collection by Dr. Michael McDonell from the Elson S. Floyd College of Medicine at Washington State University to oversee the evaluation of the New Journeys Network. The evaluation includes use of the EBP Toolkit, a secure online database that clinicians will use to document outreach activities, referral information, as well as information about consumer demographics and mental health history. Clinicians will also use the EBP Toolkit to enter and monitor clinical outcomes data in order to better target treatment interventions. All Demonstration Project sites will be required to enter evaluation and clinical monitoring data into the EBP Toolkit throughout the course of implementation.
- A partnership with Pat Deegan and Associates to provide resources and education to provider agencies to improve knowledge of recovery principles and provide access to resources for both individuals and clinicians to prepare them for meaningful engagement in their treatment. Pat Deegan and Associates will provide access to the Common Ground Academy and access to the Recovery Library for the New Journeys sites. The Recovery Library provides access to tools for recovery for individuals in recovery, family members, providers, and supporters.

The objectives of the New Journeys Network are to:

- Reduce the duration of untreated psychosis through early and appropriate detection and response, thereby potentially reducing severity of the illness.
- Minimize the disruption in the lives of adolescents and young adults who experience psychosis so they can reintegrate and maintain educational, vocational, social, and other roles.
- Minimize the societal impact of psychosis including reducing demand in other areas of the mental health and the health and social service systems and reducing disruption in the lives of families.
- Use the gathered data for quality improvement in existing programs and to improve the implementation of future sites.
- Statewide availability of CSC for FEP and support current service providers.

**9. Please explain the state’s provision for collecting and reporting data, demonstrating the impact of the 10 percent set-aside for ESMI.**

There are two prongs of data collection. The first is with the Washington State Department of Social and Health Services (DSHS), Research and Data Analysis (RDA) Division, which collects and summarizes data on DSHS clients who have experienced psychotic episodes. They provide descriptive data on demographics, behavioral health characteristics, family history (when available), services that have been required from state systems, arrests and involvement with

juvenile justice system, and trajectories from the first encounter with psychosis. RDA is using this data to operationalize a definition of First Episode Psychosis through administrative data.

Washington State University (WSU) collects program specific data pertaining to outreach activities, engagement and retention of youth and families in the New Journeys Program, clinical outcomes of participants (including program costs and savings), and individual and family experience. WSU provides both qualitative and quantitative data analysis to inform program development and implementation.

The state has contracted with the University of Washington (UW) to provide technical assistance and ongoing training and oversight in order to increase the providers' capacity to deliver services. Technical assistance includes team start-up and organizational capacity, program direction/team leadership, differential diagnosis, family education and support, peer-based services and support, and evidence-based treatments such as Individual Resiliency Training (IRT), Cognitive Behavioral Therapy (CBT) for Psychosis, and skills training. They provide direct organizational, clinical, and case-based consultation. The state and UW have also facilitated collaboration between new sites and veteran sites in order improve the implementation and program development process.

WSU will collaborate with RDA to develop a comparison study to determine the effectiveness of early psychosis intervention using the NAVIGATE Model in Washington State. RDA's mission is to provide policy makers and program managers with relevant data, analyses, and information to support innovations that improve the effectiveness of services for clients and to provide DSHS program staff and contracted service providers with access to data-driven decision support applications to improve decisions about client care. The partnership between the New Journeys Network, WSU, and RDA will provide the data required to conduct a meaningful analysis to measure the impact of this initiative.

**10. Please list the diagnostic categories identified for your state's ESMI programs:**

- Age Range: 15-25 with exceptions made up to 40 years old, based on clinical judgment and treatment match for the New Journey's Model
- Diagnoses: Schizophrenia, Schizoaffective Disorder, Schizophreniform Disorder, Brief Psychotic Disorder, or Psychotic Disorder not otherwise specified
- Duration of Illness/Symptoms: >1 week and < 2 years AND/OR < 12 months of lifetime treatment with antipsychotic medications. Only one episode of psychosis (i.e., individuals with a psychotic episode followed by full system remission and relapse to another psychotic episode are excluded)
- Exclusion Criteria: Intellectual disability (IQ > 70) and/or Autism; Psychotic symptoms secondary to 1) a pervasive developmental disorder. 2) a medical or neurologic condition. 3) prescription drug or substance use. Two or more discrete psychotic episodes.



### Person Centered Planning

*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.*

#### **1. Does your state have policies related to person centered planning?**

Yes

#### **2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.**

#### **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 Navigate 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, Navigate, and WISe services, all individuals receiving outpatient mental health services are engaged in the development of an individualized service plan. Washington Administrative Code 388-877A-0135 directs 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 at least one goal identified by the individual or their parent or legal representative and 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 Regional Service Areas 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.

### Program Integrity

*SAMHSA has placed 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 SABG 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 SABG 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 SABG 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 SABG funds are allocated to support evidence-based, culturally competent programs, substance use disorder 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 SABG. 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

**2) Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards?**

Yes

**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 Organizations (BHO) 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.

#### Tribes

*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<sup>56</sup> 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.*

*Please respond to the following items:*

**1. How many consultation sessions have the state conducted with federally recognized tribes?**

The Health Care Authority follows a communication and consultation policy that provides protocols to enhance the government to government relationships with Tribes, Urban Indian health programs, and boarder Tribes of Washington State. The Health Care Authority follows the RCW 43.376 which outline the state regulations in G2G relationships. The Office of Tribal Affairs assists DBHR in implementation of various consultation and confirm meetings with the 29 Tribes and Urban Indian health programs.

In the past year, there have been several consultation on both physical and behavioral health program implementation and policy development.

- January 22, 2018 - Consultation on 1115 Amendments. The amendment specifically requested the use of Medicaid funds for SUD services in institutions for mental disease (IMDs) and technical corrections to the 115 demonstration's Special Terms and Conditions.
- Consultation on the Swinomish Dental Health Aid Therapy
- April 5, 218 - Consultation on Dental Managed Care Request for Proposals (RFP).
- April 30, 2018 - Consultation on behavioral health integration (BHI) and work with Tribes and urban Indian health programs through the changes due to BHI activities related to HB 1388.
- July 31, 2018 - Consultation on the State Opioid Response application.
- August 23, 2018 - Consultation on Block Grant Biennial Grant Update.
- September 5, 2018 - Consultation on Managed Care Dental 1915b Waiver.
- November 14, 2018 - Consultation on Block Grant progress report.
- February 25, 2019 - Consultation on State Plan Amendment to add SUD Peer Services to the state plan for Medicaid services.
- February 25, 2019 – Consultation on the Tribal Evaluation and Treatment Facility Plan.
- May 28, 2019 – Consultation on Washington State Integrated Care for Kids Model Application to CMS.
- August 5, 2019 – Consultation on 2020-2021 Block Grant Application to SAMHSA.
- August 7, 2019 – Consultation on TrueBlood Settlement Implementation Plan.
- Upcoming TBD – Consultation on Indian Nation Program Agreements (new contracting process for Tribal governments through HCA).
- Upcoming TBD – Consultation on revised HCA Consultation and Communication Policy.
- Upcoming TBD – Consultation request to use Medicaid funds for MH service in institutions of mental disease (IMDs) to be added to the 1115 demonstration waiver.

## **2. What specific concerns were raised during the consultation session(s) noted above?**

- Tribal and Urban Indian Health program leaders wish to continue to have the option for AI/AN individuals to be exempted from managed care for behavioral health and dental health services.
- Lack of access to behavioral health services through the FFS program and state funded crisis services.
- Lack of funding and carve out opportunities from the Block Grant projects for Tribal Governments. Tribes would like to have tribal specific programs in each of the categories such as prevention, treatment, and recovery support services that are equitable to what is provided to other entities.
- Request assistance in working with state partners that hold funding resources such as Behavioral Health Organizations (BHOs), Administrative Services Organizations for behavioral health (BH-ASOs), counties, superior courts, non-tribal health care providers, Accountable Communities Of Health (ACHs), colleges, Managed Care Organizations (MCOs), etc.

Lack of understanding by state agency staff and partners (contractors) on the Indian Health Care system which creates barriers and disparities in programming in regards to burdensome reporting, lack of resource development for Tribes and IHCPs, focus on EBPS that do not include

tribal best practices, lack of acknowledgement of Tribal sovereignty, and cultural appropriate services.

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

The Health Care Authority is in the process of revising the HCA collaboration and consultation policy. Highlights of the changes include:

- Development and implementation of 4 regional Tribal liaisons to work individually with Tribes and Urban programs in their perspective locations.
- Establishment of Division Tribal Coordination staff. Each division has the responsibility to assign key staff to this role.
- Formalization of Tribal Coordination planning with each Tribe on an annual basis.
- Formalization and technical assistance around increased responsibilities for Tribal notification for division policy development, program development, and key items that impact AI/AN population to Tribal governments. Template Tribal notification has been developed for this policy.

In addition to the revision to the HCA policy, the State Governor's Office of Indian Affairs is working with various state agencies to develop and establish a template and core consultation policies to be incorporated by each State agency. This template will be presented at the 30 Annual Centennial Accord meeting in Sept/Oct 2019. The SAMHSA Consultation Policy was considered and reviewed in the development of both the HCA Consultation and Communication Policy and the template GOIA policy. No additional technical assistance is needed at this time.

The Health Care Authority has increased activities and efforts to address behavioral health concerns over the past several years. These increased and continued efforts are listed below.

- In response to the work over many year from the Tribal Centric Behavioral Health Workgroup, in 2017, the state legislature directed the DBHR to support the development of a Tribal Evaluation and Treatment Workgroup to develop a plan to stand up a culturally appropriate E&T facility that is supported through state and federal resources. The workgroup has completed its planning process and will be shared in the summer of 2019. The plan provide a comprehensive set of recommendations that includes a plan to stand up an E&T Facility for individuals with MH and SUD (Secure Withdraw Management) needs. The workgroup recommended that the facility be managed by a consortium of Tribes with representatives from at least one person per region that extends to a statewide advisory committee. In additional to the facility, the workgroup provided recommendations on the clinical and cultural programming, plan for funding resources to stand up the site and work with HCA and Indian Health Services to cover operational costs. There were also several legislative recommendations that the workgroup would like to pursue to ensure the success and development of a tribal centric crisis system including the development of a Tribal Crisis Coordination Hub, Tribal Designated Crisis Responders, and Tribal court reciprocity to hear cases of the Involuntary Treatment Act. The intent of this project is to ensure that there is available beds for voluntary and involuntary treatment of MH and SUD disorders for AI/AN that are culturally appropriate for individuals in need of crisis services.



- DBHR has worked over the last two years and included tribal representatives on the work of the SUD Peer expansion of services. DBHR has many tribal representative on their statewide workgroup and participated in consultation to add these services to the State Medicaid Plan as an amendment. Additionally, DBHR has partnered to work on the Tribal initiated developed of the Community Health Aid Program and development of the Behavioral Health Aid provider type to WA State. Tribal leaders are considering adding SUD and MH Peer curriculum as part of the BHA training.
- Several funding resources that have been provided to WA State to combat the opioid crisis has been significant over the past couple of years. DBHR has increased several projects with Tribal governments and Urban Indian Health Programs.
  - The HCA has successfully completed and launched the Opioid Resources and Media Campaign for tribal and urban Indian communities through the Tribal Opioid Solutions campaign and resources “It Starts with One” (prevention) and “Journey to Recovery” (treatment) that can be found on [www.tribalopioidsolutions.com](http://www.tribalopioidsolutions.com). There has been great feedback from Tribal leaders on the success and partnership of the work with Tribal representative on the development of materials.
  - The HCA was directed by the legislature in 2018 to provide funding to Tribal governments in the amount of 1.4 million dollars to support opioid response project which allowed each Tribe to access up to \$50,000 for prevention or treatment services.
  - Through the State Opioid Response Grant application in which DBHR participated in consultation on, several projects were developed through the funding resources. An additional \$464,000 was set aside to fund 2 Urban Indian Health Programs for opioid response in the amount of \$50,000 each, \$315,000 was provided as requested by Tribes to support unmet need from block grant resources and \$40,000 was provided to the American Indian Health Commission to establish an American Indian/Alaskan Native Opioid Response Workgroup (AI/AN ORW). The workgroup was established to develop recommendations of goals, objectives, and strategies to address the opioid crisis specifically in Indian county to be added to the WA State Opioid Response Plan.
  - The Tribal Opioid Response Grant was discussed intently through the SOR roundtable and consultation process. Partnerships emerged and minimal technical assistance was provided. Twenty one of the 29 federally recognized tribes accessed funding through the TOR grant resulting in over 4.7 million additional funds for tribal governments were accessed in the state of Washington.
- HCA continues to foster the Fee-For-Service Program for AI/AN for behavioral health services for AI/AN individuals that have elected to opt out of managed care. The FFS program has increased the number of providers to serve AI/AN individuals through continued outreach, and access to care problem solving efforts. The FFS program for AI/AN also developed a web resource to identify providers that have signed up to take individuals on the FFS for AI/AN Medicaid program.



<http://www.arcgis.com/home/webmap/viewer.html?webmap=7b27770161da499d999db2182c40a3a9>

- Through the TR Settlement and establishment of Wrap Around for Intensive Services (WISe) that was launched statewide, Tribal governments expressed concerns of lack of access to resources, lack of consultation and conference with Tribes and Urban Indian Health programs on the development of the curriculum, and training materials for WISe team members. As of now, all WISe teams are contracted through non-tribal entities and BHOs, BH-ASOs. The WISe staff at HCA worked to establish a network of WISe teams that opted into the FFS for AI/AN program to provide services for AI/AN youth that are opted out of managed care. In addition to addressing this concerns, the WISe staff at HCA also accessed funding through the MH Block Grant to support the adaptation and enhancement of the WISe training curriculum, establishment of Medicaid billing mechanism for tribal governments to bill for WISe services, and increase tribal and urban Indian program on current WISe teams or development of their own WISe teams. The workgroup with Tribal leaders and urban Indian health programs was established in May 2019 and will run through September 2019.
- Integration efforts continue to move forward which has resulted in the establishment of new contracting process through the Health Care Authority that is being finalized internally and will be consulted with the Tribes to enhance contracting efficiencies and reduce burdensome contracting requirements. In addition, the HCA is working on a revision of their tribal consultation and communication policy in consultation with Tribes to increase access to resources to Tribes, honors RCW 43.376 and federal consultation guidelines, and increased partnerships in program and policy development in consultation and conference with tribal governments and urban Indian health providers. Tribes also access direct funding from the 1115 waiver to enhance integration projects in their communities. Over X million is provided to Tribes for integration projects that is managed by the Office of Tribal Affairs.

### Primary Prevention

*SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified 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 disorder 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 SABG 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.*

*Please respond to the following questions:*

## **Assessment**

### **1. Does your state have an active State Epidemiological and Outcomes Workgroup (SEOW)?**

Yes. Washington State has an active State Epidemiological Outcomes Workgroup (SEOW), which meets quarterly. The SEOW was first established in January 2005, as part of the Strategic Prevention Framework State Incentive Grant (SPF SIG), and has been active since then. It is currently housed in the Health Care Authority Division of Behavioral Health and Recovery (HCA/DBHR) and is co-chaired by leadership at the Department of Health (DOH). Core members include representatives from the Department of Social and Health Services (Division of Research and Data Analysis), the additional DOH staff, Washington State Institute for Public Policy, the University of Washington. The SEOW also includes tribal representatives.

The purpose of the SEOW is to support the development and use of robust and meaningful measures that allow data-driven policy decisions and program planning to prevent substance abuse and to promote mental health. 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 developed and biennially updates the Prevention Needs Assessment for the Strategic Prevention Enhancement Consortium Strategic Plan.

### **2. Does your state collect the following types of data as part of its primary prevention assessment process?**

Yes. This assessment includes data on:

- a. Long term health and social consequences of substance-using behaviors;

- b. Substance-using behaviors;
- c. Intervening variables (risk and protective factors); and
- d. Local contributing factors.

**3. Does your state collect needs assessment data that include analysis of primary prevention needs for the following population groups?**

Washington collects needs assessment data on the following population groups:

- i. Children (under age 12);
- ii. Youth (ages 12-17);
- iii. Young adults/college age (age 18-26);
- iv. Adults (ages 27-54);
- v. Older adults (age 55 and above);
- vi. Gender and sex;
- vii. Cultural/ethnic minorities;
- viii. Sexual/gender minorities; and
- ix. Rural communities.

**4. Does your state use data from the following sources in its primary prevention needs assessment?**

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, and Monitoring the Future. Washington additionally uses two state-developed survey instrument: the Healthy Youth Survey and the Young Adult Health Survey.

The following Archival indicators are used as well:

- WA Department of Health and DSHS Research and Data Analysis:
  - Alcohol related injury/accident (hospitalization);
  - Other drugs related injury/accident (hospitalization);
  - Tobacco related deaths;
  - Alcohol related deaths;
  - Other drug deaths – Drug related deaths;
  - Opioid related deaths – All Opioids; Prescription; Heroin.
- Uniform Crime Reporting:
  - Arrests - Alcohol Violation;
  - Arrests – Alcohol Related;
  - Arrests – Drug Violation;
  - Arrests – Drug Related.
- Office of Superintendent of Public Instruction:
  - HS Extended Graduation Rate (includes on-time graduation).
- Comprehensive Hospital Abstract Reporting System (CHARS):
  - Suicide and attempts.
- WA Department of Transportation and WA State Highway Safety Commission
  - Fatalities and Serious Injury from Crashes: Alcohol-Related Traffic Injuries and Alcohol-Related Traffic Fatalities.
- Washington Healthy Youth Survey:
  - Underage Drinking (10<sup>th</sup> Grade);

- Marijuana Misuse/Abuse (10<sup>th</sup> Grade);
- Prescription Misuse/Abuse (10<sup>th</sup> Grade);
- Pain Killer User (10<sup>th</sup> Grade)
- Tobacco Misuse/Abuse (10<sup>th</sup> Grade);
- E-Cigarette/Vapor Products Misuse/Abuse (10<sup>th</sup> Grade);
- Polysubstance Misuse/Abuse (10<sup>th</sup> Grade);
- Sad/Hopeless in Past 12 Months (10<sup>th</sup> Grade);
- Suicide Ideation (10<sup>th</sup> Grade);
- Suicide Plan (10<sup>th</sup> Grade);
- Suicide Attempt (10<sup>th</sup> Grade);
- Bullied/Harassed/Intimidated (10<sup>th</sup> Grade);
- Source of Alcohol, Pain Killers Used to Get High; Marijuana; Vapor Products(10<sup>th</sup> Grade);
- Perception of Availability of Alcohol, Marijuana, Cigarettes; Opioids (10<sup>th</sup> Grade);
- Risk Perception of Alcohol, Marijuana (10<sup>th</sup> Grade); and
- Knowledge of Laws, Perception of Enforcement – Alcohol, Marijuana (10<sup>th</sup> Grade),
- Washington Young Adult Health Survey:
  - Young Adult (18-25) Marijuana Misuse/Abuse;
  - Opioid Misuse/Abuse;
  - Alcohol Use; and
  - Source of Marijuana.
- Pregnancy Risk Assessment Monitoring System (PRAMS):
  - Pregnant Women Report Alcohol Use Any Time During Pregnancy
- Washington State Liquor and Cannabis Control Board:
  - Count of State Liquor Licenses;
  - Count of State Marijuana Store Licenses and Processor Licenses

**5. Does your state use needs assessment data to make decisions about the allocation SABG primary prevention funds?**

Yes. Washington State uses data prepared by the state SEOW to support its substance use prevention needs assessment and to support decision-making regarding the allocation to high need communities of SABG primary prevention funds related to underage alcohol, tobacco, prescription drugs/opioids, and marijuana use, misuse, and abuse.

**Capacity Building**

**6. Does your state have a statewide licensing or certification program for the substance misuse prevention workforce?**

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 with the 2015-2017 contracts, DBHR contractually required credentialing of community coalition coordinators.

**7. Does your state have a formal mechanism to provide training and technical assistance to the substance misuse prevention workforce?**

Yes. DBHR provides training and technical assistance for communities and prevention providers as they implement prevention services. There are currently three DBHR staff with significant assignments that include workforce development and implementing the prevention training plan. 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:
  - New Coordinator Training – overview of Community Prevention and Wellness Initiative and SPF Models.
  - Community Data Book Training – how to use data to conduct a community needs assessment.
  - Goals, Objectives, Strategy Selection Training – how to prioritize local conditions and intervening variables to select program objectives and outcomes.
  - Evaluation Training – how to conduct an evaluation of programs and use results
  - 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.
  - 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.
  - In calendar year 2018, training topics *Balancing Fidelity and Adaptation: A Best Practices Guide for Evidence-based Program Implementation* where the presenters provided information to increase attendees capacity with implementing evidence-based programs and *ACES 101*, a two-part session that provided attendees with an overview of ACES and how to incorporate ACES into prevention programming.
- Monthly Training: DBHR hosts on-going, optional monthly training sessions during the 3<sup>rd</sup> hour of the on-line monthly CPWI Learning Community Meetings attended by sub-recipients.
  - Webinar training topics in calendar year 2018 included: *Washington State Opioid Awareness Campaign – It Starts with One; Leveraging Funding & Community: Building a Comprehensive School-based Behavioral Health System in Monroe School District*; and *Student Assistance Prevention & Intervention Services Program*.
- DBHR Technical Assistance Training and On-going Support:
  - 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);
- 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](http://www.theAthenaForum.org).

**8. Does your state have a formal mechanism to assess community readiness to implement prevention strategies?**

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.

**Planning**

**9. Does your state have a strategic plan that addresses substance misuse prevention that was developed within the last five years?**

Yes. The current State of Washington Substance Abuse and Mental Health Promotion Five-Year Strategic Plan was developed in 2012. It was updated in 2015 and 2017, and both past plans and the current plan are posted at [www.TheAthenaForum.org/spe](http://www.TheAthenaForum.org/spe). The plan is currently being updated and is projected to be completed in fall 2019.

**10. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SABG?**

Yes. Data prepared by the state SEOW supports the state's decision-making process regarding the use of the primary prevention set-aside of the SABG. The strategic plan is a guide for funding local prevention services and for dedicating state resources for local, regional, and state efforts.

**11. Does your state's prevention strategic plan include the following components?**

The state's prevention strategic plan includes the following components:

- Based on needs assessment datasets, the priorities that guide the allocation of SABG prevention funds;
- Timelines;
- Roles and responsibilities;



- Process indicators;
- Outcome indicators;
- Cultural competence component;
- Sustainability component.
- Other:
  - Resource assessment.
  - Prevention research theories.

**12. Does your state have an Advisory Council that provides input into the decisions about the use of SABG primary prevention funds?**

Yes. The Washington State Prevention Enhancement Policy Consortium (the Consortium) provides this function. The Consortium is comprised of representatives from 26 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 abuse prevention programming, mental health promotion programming, and programming for related issues.

**13. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SABG primary prevention funds? 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 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 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.

**Implementation**

**14. States distribute SABG primary prevention funds in a variety of different ways. Please check all that apply to your state:**

The following apply in WA:

- SSA staff directly implements primary prevention programs and strategies;
- The SSA has statewide contracts;
- The SSA funds regional entities to provide prevention services;
- The SSA funds county, city, or tribal government to provide prevention services; and
- The SSA funds community coalitions to provide prevention services.

**15. Please list the specific primary prevention programs, practices, and strategies that are funded with SABG primary prevention dollars in each of the six prevention strategies.**

Along with the information presented here, the list of evidence-based programs and practices (direct and environmental) are posted in a searchable database found on the Athena Forum website ([www.TheAthenaForum.org/ebp](http://www.TheAthenaForum.org/ebp)).

**Community-based Process** – SABG supports the daily and ongoing community work of the Community Coalition Coordinator that staffs and supports the local (required) community coalition in each of our selected CWPI communities. Funding for this category also supports the Tribal prevention coordinator to implement prevention programs via the Government to Government contracts.

**Information dissemination** – SABG funding will continue to support each CPWI community coalition/tribal program to raise awareness of the community coalition efforts, strategies, messages, programs and the high-risk needs or promotion of protective factors within the community.

**Problem Identification and Referral** – SABG funding will continue to support a contract with the Office of Superintendent of Public Instruction (OSPI) to implement “Project Success” and sustain full time prevention/intervention staff in each CPWI community.

**Education** – SABG funding will continue to support prevention services that provide education and communication from educators/facilitators to program participants according to annual plans.

**Alternatives** – SABG funding supports programs that incorporate services that provide activities that exclude substance use. Alternative activities are used in some communities to complement educational programs and strategies. We discourage alternative activities alone to be used.

**Environmental** – SABG funds support communities to implement strategies that address community identified priorities to impact community-level change. Strategies focus on community norms, policies, and attitudes 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	Across Ages
Alternatives	Big Brothers Big Sisters Mentoring Program
Community-Based Processes	Communities that Care (CTC)
Community-Based Processes	Gathering of Native Americans
Community-Based Processes	PROSPER
Education	Alcohol Literacy Challenge (ALC)
Education	All Stars

Education	Al's Pals: Kids Making Healthy Choices
Education	Athletes Training & Learning to Avoid Steroids
Education	ATLAS (Athletes Training and Learning to Avoid Steroids)
Education	Brief Alcohol Screening and Intervention for College Students (BASICS)
Education	Brief Strategic Family Therapy
Education	Child Development Project
Education	Children In Between
Education	Class Action
Education	Coping Power
Education	Coping with Work and Family Stress
Education	Creating Lasting Family Connections (CLFC)
Education	Curriculum Based Support Group Program (CBSG)
Education	DARE to Be You (DTBY)
Education	Early Risers--Skills for Success
Education	Familias Unidas
Education	Families and Schools Together (FAST)
Education	Family Effectiveness Training (FET)
Education	Family Matters
Education	Family Spirit
Education	Friendly PEERsuasion
Education	Good Behavior Game
Education	Guiding Good Choices
Education	Healer Women Fighting Disease Integrated Substance Abuse and HIV Prevention for African American Women (HWFD)
Education	Healing of the Canoe
Education	Healthy Alternatives for Little Ones (HALO)
Education	Healthy Living Project for People Living with HIV
Education	Healthy Workplace
Education	Hip-Hop 2 Prevent Substance Abuse and HIV (H2P)
Education	Home-Based Behavioral Systems Family Therapy
Education	I Can Problem Solve (ICPS)
Education	I'm Special
Education	Incredible Years
Education	Keep A Clear Mind
Education	Keepin' it REAL
Education	Life Skills Training Program (LST)
Education	Lions Quest Skills for Adolescence
Education	Media Detective
Education	Media Ready

Education	Native American Prevention Project Against AIDS and Substance Abuse (NAPPASA)
Education	Not On Tobacco (NOT)
Education	Nurse Family Partnership
Education	Nurturing Parenting Programs
Education	Parent Management Training
Education	Parenting Wisely
Education	Parents as Teachers
Education	Peacemakers
Education	Peer Assistance and Leadership (PAL)
Education	Positive Action
Education	Positive Indian Parenting
Education	PRIME for Life
Education	Project ALERT
Education	Project EX
Education	Project Northland
Education	Project SUCCESS
Education	Project Towards No Drug Abuse
Education	Project Towards No Tobacco Use
Education	Project Venture
Education	Promoting Alternative Thinking Strategies (PATHS),PATHS Preschool
Education	Protecting You/Protecting Me
Education	Raising Healthy Children (using SSDP model)
Education	Reconnecting Youth: A Peer Group Approach to Building Life Skills
Education	Red Cliff Wellness School Curriculum
Education	Residential Student Assistance Program (RSAP)
Education	Say it Straight
Education	Schools and Families Educating Children (SAFEChildren)
Education	Second Step
Education	Sembrando Salud
Education	SMART Leaders
Education	Social Competence Promotion Program for Young Adolescents (SCPP-YA)
Education	SPORT
Education	STARS for Families
Education	State-wide Indian Drug Prevention
Education	Stay on Track
Education	Storytelling for Empowerment
Education	Strengthening Families Program
Education	Strengthening Families Program: for Parents and Youth 10-14
Education	Strengthening Multi-Ethnic Families and Communities

Education	Strong African American Families
Education	Team Awareness
Education	Teen Intervene
Education	Too Good for Drugs
Education	Wellness Outreach at Work
Environmental	Advertising Restrictions
Environmental	Blood Alcohol Concentration Laws (Per se Laws)
Environmental	Border-Binge Drinking Reduction Program
Environmental	Challenging College Alcohol Abuse
Environmental	Changing Hours and Days of Sale
Environmental	Communities Mobilizing for Change on Alcohol (CMCA)
Environmental	Community Trials Intervention to Reduce High-Risk Drinking
Environmental	Community Trials Intervention to Reduce High-Risk Drinking (adapted for marijuana)
Environmental	Compliance Checks
Environmental	Densities or Concentration of Retail Outlets- Changing Conditions of Availability
Environmental	Drinking Locations and Possession of Alcohol--Changing Conditions of Availability
Environmental	Drug Impairment Training for Educational Professionals (DITEP)
Environmental	Economic Interventions (Increasing Taxes)
Environmental	Interlock Devices
Environmental	Keg Registration-Changing Conditions of Availability
Environmental	License Suspension/Revocation
Environmental	Lower Levels of Alcohol in Beverages
Environmental	Party Intervention Patrols
Environmental	Policy Review and Development
Environmental	Project ACHIEVE
Environmental	Project STAR/Midwestern Prevention Project
Environmental	Purchase Surveys coupled with Reward and Reminder
Environmental	Raising the Minimum Drinking Age
Environmental	Responsible Beverage Service
Environmental	Restricting Access to Alcohol at Social Events--Changing Conditions of Availability
Environmental	Restrictions at Community Events
Environmental	Restrictions on Price Promotions and Alcohol Discounts--Changing Conditions of Availability
Environmental	Reward and Reminder
Environmental	School Policies
Environmental	Sobriety Checkpoints
Environmental	Social Host Ordinance
Environmental	Social Norms Marketing

Environmental	Source Investigation Training (Reducing Social and Third Party Access)
Environmental	State Retail Monopolies
Environmental	Tobacco-Free Environmental Policies
Environmental	Zero Tolerance Laws

**16. Does your state have a process in place to ensure that SABG dollars are used only to fund primary prevention services not funded through other means?**

Yes. 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.

**Evaluation**

**17. Does your state have an evaluation plan for substance misuse prevention that was developed within the last five years?**

Yes. DBHR has an evaluation plan that was developed in 2015. Managed by Washington State University, the purpose of the evaluation is to examine change in substance use and related risk factors in communities receiving funding for local prevention services through DBHR. The research questions are described below.

**18. Does your state’s prevention evaluation plan include the following components?**

Washington’s plan includes the following components:

- Establishing methods for monitoring progress toward outcomes, such as targeted benchmarks – via the state Substance Use Prevention and Mental Health Promotion Online Management Information System (SUD Prevention and MH Promotion MIS);
- Includes evaluation information from sub-recipient – via the SUD Prevention and MH Promotion MIS;
- Includes SAMHSA National Outcome Measurement (NOMs) Requirements;
- Establishes a process for providing timely evaluation information to stakeholders;
- Formalizes a process for incorporating evaluation findings into resource allocation and decision-making.
- Other:
  - Reports to sub-recipients
  - Evaluation of trainings offered by DBHR

Washington additionally contracts with Washington State University for assessment of the effectiveness of the impact of the Community Prevention and Wellness Initiative. This assessment approached this evaluation through three specific questions: Did 10<sup>th</sup> Grade substance use and risk factors decrease in CPWI communities from 2008 (Cohort 1) or 2010 (Cohort 2& 3) to 2016?; Did CPWI communities close the gap with respect to a number of substance use outcomes and risk factors; Are the trends across time different for CPWI communities than for Washington trends as a whole?



**19. Please check those process measures listed below that your state collects on its SABG funded prevention services:**

Washington collects the following measures:

- Numbers served (for individual participants, aggregate counts, and population reach);
- Implementation fidelity;
- Participant satisfaction;
- Number of evidence based programs/practices/policies implemented;
- Attendance;
- Demographic information (age, race, ethnicity, income, language spoken, language ability, location, family military status; and
- Other:
  - Service hours.

**20. Please check those outcome measures listed below that your state collects on its SABG funded prevention services:**

- WA Department of Health and DSHS Research and Data Analysis:
  - Alcohol related injury/accident (hospitalization);
  - Other drugs related injury/accident (hospitalization);
  - Tobacco related deaths;
  - Alcohol related deaths;
  - Other drug deaths – Drug related deaths;
  - Opioid related deaths – All Opioids; Prescription; Heroin.
- Uniform Crime Reporting:
  - Arrests - Alcohol Violation;
  - Arrests – Alcohol Related;
  - Arrests – Drug Violation;
  - Arrests – Drug Related.
- Office of Superintendent of Public Instruction:
  - HS Extended Graduation Rate (includes on-time graduation).
- Comprehensive Hospital Abstract Reporting System (CHARS):
  - Suicide and attempts.
- WA Department of Transportation and WA State Highway Safety Commission
  - Fatalities and Serious Injury from Crashes: Alcohol-Related Traffic Injuries and Alcohol-Related Traffic Fatalities.
- Washington Healthy Youth Survey:
  - Underage Drinking (10<sup>th</sup> Grade);
  - Marijuana Misuse/Abuse (10<sup>th</sup> Grade);
  - Prescription Misuse/Abuse (10<sup>th</sup> Grade);
  - Pain Killer User (10<sup>th</sup> Grade)
  - Tobacco Misuse/Abuse (10<sup>th</sup> Grade);
  - E-Cigarette/Vapor Products Misuse/Abuse (10<sup>th</sup> Grade);
  - Polysubstance Misuse/Abuse (10<sup>th</sup> Grade);
  - Sad/Hopeless in Past 12 Months (10<sup>th</sup> Grade);

- Suicide Ideation (10<sup>th</sup> Grade);
- Suicide Plan (10<sup>th</sup> Grade);
- Suicide Attempt (10<sup>th</sup> Grade);
- Bullied/Harassed/Intimidated (10<sup>th</sup> Grade);
- Source of Alcohol, Pain Killers Used to Get High; Marijuana; Vapor Products(10<sup>th</sup> Grade);
- Perception of Availability of Alcohol, Marijuana, Cigarettes; Opioids (10<sup>th</sup> Grade);
- Risk Perception of Alcohol, Marijuana (10<sup>th</sup> Grade); and
- Knowledge of Laws, Perception of Enforcement – Alcohol, Marijuana (10<sup>th</sup> Grade),
- Washington Young Adult Health Survey:
  - Young Adult (18-25) Marijuana Misuse/Abuse;
  - Alcohol Use; and
  - Source of Marijuana.
- Pregnancy Risk Assessment Monitoring System (PRAMS):
  - Pregnant Women Report Alcohol Use Any Time During Pregnancy
- Washington State Liquor and Cannabis Control Board:
  - Count of State Liquor Licenses;
- Count of State Marijuana Store Licenses and Processor Licenses

#### Statutory Criterion for MHBG

##### **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.*

#### **1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occurring 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 cover a wide variety of services in support of the individuals in their catchment area to live in their communities. At the lower service level there is brief intervention. Some examples of the services provided on a community level include crisis services, outpatient mental health counseling, group and family treatment, case management, medication management, and medication monitoring. There are also higher level of outpatient resources such as intensive services for youth and families, respite services, and the program of assertive community treatment (PACT). 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?**

- a. **Physical health**  
Yes
- b. **Mental health**  
Yes
- c. **Rehabilitation services**  
Yes
- d. **Employment services**  
Yes
- e. **Housing services**  
Yes
- f. **Education services**  
Yes
- g. **Substance misuse prevention and SUD treatment services**  
Yes
- h. **Medical and dental services**  
Yes
- i. **Support services**  
Yes
- j. **Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)**  
Yes
- k. **Services for persons with co-occurring M/SUDs**  
Yes

**3. Describe your state's case management services**

While generic case management services are not included in Washington's Medicaid State Plan. However, 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 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.

**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.*

*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	103,208	N/A
2. Children with SED	40,319	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 a HCA approved algorithm with known limitations.

Washington State does not have a methodology or data to estimate incidence rates.

**Criterion 3: Children’s Services**

*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

**b) Educational services, including services provided under IDE**

Yes

**c) Juvenile justice services**

Yes

**d) Substance misuse prevention and SUD treatment services**

Yes

**e) Health and mental health services**

Yes

**f) Establishes defined geographic area for the provision of the services of such system**

Yes

**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.*

**Describe your state's targeted services to rural population.**

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.

**Describe your state's targeted services to the homeless population.**

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.

**Describe your state's targeted services to the older adult population.**

In regards to 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.

**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.*

**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.

*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.

Substance Use Disorder Treatment

**Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs.**

**Improving access to treatment services**

**1. Does your state provide:**

**a) A full continuum of services:**

**i) Screening**

Yes

**ii) Education**

Yes

**iii) Brief intervention**

No

**iv) Assessment**

Yes

**v) Detox (inpatient/social)**

Yes

**vi) Outpatient**

Yes

**vii) Intensive outpatient**

Yes

**viii) Inpatient/residential**

Yes

**ix) Aftercare; recovery support**

Yes

**b) Services for special populations:**

**Targeted services for veterans?**

No

**Adolescents?**

Yes

**Older adults?**

No

**Medication-Assisted Treatment (MAT)?**

Yes

**Criterion 2: Improving Access and Addressing Primary Prevention – see Section 8**

**Criterion 3: Pregnant Women and Women with Dependent Children (PWWDC)**

**1. Does your state meet the performance requirement to establish and or maintain new programs or expand programs to ensure treatment availability?**

a) Yes

**2. Does your state make prenatal care available to PWWDC receiving services, either directly or through an arrangement with public or private nonprofit entities?**

a) Yes

**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?**

a) Yes

**4. Does your state have an arrangement for ensuring the provision of required supportive services?**

a) Yes

**5. Has your state identified a need for any of the following:**

**a) Open assessment and intake scheduling?**

Yes

**b) Establishment of an electronic system to identify available treatment slots?**

No

**c) Expanded community network for supportive services and healthcare?**

Yes

**d) Inclusion of recovery support services?**

Yes

**e) Health navigators to assist clients with community linkages?**

Yes

**f) Expanded capability for family services, relationship restoration, and custody issues?**

Yes

**g) Providing employment assistance?**

Yes

**h) Providing transportation to and from services?**

Yes

**i) Educational assistance?**

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 women are contained within the contract language between the state of Washington, the Behavioral Health Organizations (BHOs), and the Fully Integrated Managed Care (FIMC) regions. The BHOs and FIMC 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 BHOs and FIMC work with agencies to get pregnant women into services within 24 hours, 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 women in 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 BHOs and FIMC 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.

**Criteria 4, 5 and 6: Persons Who Inject Drugs (PWID), Tuberculosis (TB), Human Immunodeficiency Virus (HIV), Hypodermic Needle Prohibition, and Syringe Services Program  
Persons Who Inject Drugs (PWID)**

**1. Does your state fulfill the:**

**a) 90 percent capacity reporting requirement?**

Yes

**b) 14-120 day performance requirement with provision of interim services?**

Yes

**c) Outreach activities?**

Yes

**d) Syringe services programs?**

Yes

**e) Monitoring requirements as outlined in the authorizing statute and implementing regulation?**

Yes

**2. Has your state identified a need for any of the following:**

**a) Electronic system with alert when 90 percent capacity is reached?**

No

**b) Automatic reminder system associated with 14-120 day performance requirement?**

No

**c) Use of peer recovery supports to maintain contact and support?**

Yes

**d) Service expansion to specific populations (e.g., military families, veterans, adolescents, older adults)?**

Yes

**3. States are required to monitor program compliance related to activities 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, the Behavioral Health Organizations (BHO), and the Fully Integrated Managed Care (FIMC) Organizations. The BHOs and FIMC 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 BHOs and the FIMC must ensure that outreach is provided to priority populations. The outreach activities must specifically designed to reduce transmission of HIV and encourage PWID to undergo treatment.

If treatment services are not immediately available 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 BHOs and FIMC 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 BHOs and FIMC 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

**2. Has your state identified a need for any of the following:**

**a) Business agreement/MOU with primary healthcare providers?**

No

**b) Cooperative agreement/MOU with public health entity for testing and treatment?**

Yes

**c) Established co-located SUD professionals within FQHCs?**

Yes

**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 BHOs and the FIMC 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 on the basis of the lack of capacity the BHO will refer the individual to another provider of tuberculosis services. The BHOs and FIMC must conduct case management activities to ensure the individual receives tuberculosis services.

### **Syringe Service Programs**

**1. Does your state have in place an agreement to ensure that SABG funds are NOT expended to provide individuals with hypodermic needles or syringes (42 U.S.C.§ 300x-31(a)(1)F)?**

Yes



**2) Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program?**

Yes

**3) Do any of your programs use SABG funds to support elements of a Syringe Services Program?**

Yes

**If yes, please provide a brief description of the elements and the arrangement**

The BHOs and FIMC are encouraged to provide outreach and engagement services to PWID individuals. However, the contracts with the BHOs and FIMC clearly identify that funding cannot be used to purchase hypodermic needles or syringes.

**Criteria 8, 9 and 10: Service System Needs, Service Coordination, Charitable Choice, Referrals, Patient Records, and Independent Peer Review**

#### **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

**2. Has your state identified a need for any of the following:**

**a) Workforce development efforts to expand service access?**

Yes

**b) Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services?**

Yes

**c) Establish a peer recovery support network to assist in filling the gaps?**

Yes

**d) Incorporate input from special populations (military families, service members, veterans, tribal entities, older adults, sexual and gender minorities)**

Yes

**e) Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, such as primary healthcare, public health, VA, and community organizations**

Yes

**f) Explore expansion of services for:**

**i) MAT**

Yes

**ii) Tele-health**

Yes

**iii) Social media outreach**

Yes

**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

**b) Establish a program to provide trauma-informed care**

Yes

**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 system, adult criminal justice system, and education**

Yes

**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

**2. Does your state provide any of the following:**

**a) Notice to Program Beneficiaries?**

No

**b) An organized referral system to identify alternative providers?**

Yes

**c) A system to maintain a list of referrals made by religious organizations?**

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

**2. Has your state identified a need for any of the following:**

**a) Review and update of screening and assessment instruments?**

Yes

**b) Review of current levels of care to determine changes or additions?**

Yes

**c) Identify workforce needs to expand service capabilities?**

Yes

**d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background?**

Yes

#### **Patient Records**

**1. Does your state have an agreement to ensure the protection of client records?**

Yes

**2. Has your state identified a need for any of the following:**

**a) Training staff and community partners on confidentiality requirements?**

Yes

**b) Training on responding to requests asking for acknowledgement of the presence of clients?**

Yes

**c) Updating written procedures which regulate and control access to records?**

No

**d) Review and update of the procedure by which clients are notified of the confidentiality of their records include the exceptions for disclosure?**

Yes

#### **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

**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 BHOs and FIMC 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. This year 26 substance abuse providers and 11 mental health providers have been reviewed, the state expects to review the same number of providers in FFY20 and FFY21.

**3. Has your state identified a need for any of the following:**

**a) Development of a quality improvement plan?**

Yes

**b) Establishment of policies and procedures related to independent peer review?**

Yes

**c) Development of long-term planning for service revision and expansion to meet the needs of specific populations**

Yes

**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

**If Yes, please identify the accreditation organization(s)**

i) Commission on the Accreditation of Rehabilitation Facilities

ii) The Joint Commission

iii) Other (please specify)           X          

Providers have the choice to be accredited by the Commission on the Accreditation of Rehabilitation Facilities or the Joint Commission but it is not mandatory. However, providers do have to be licensed and certified by DBHR.

#### **Criterion 7 and 11: Group Homes for Persons In Recovery and Professional Development**

##### **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

**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

**b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing?**

Yes

### 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

**b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services?**

Yes

**c) Performance-based accountability?**

Yes

**d) Data collection and reporting requirements?**

Yes

**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

**b) Addition of training sessions designed to increase employee understanding of recovery support services?**

Yes

**c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services?**

Yes

**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

**3. Has your state utilized the Regional Prevention, Treatment and/or Mental Health Training and Technical Assistance Centers (TTCs)?**

**a) Prevention TTC?**

Yes

**b) Mental Health TTC?**

No

**c) Addiction TTC?**

Yes

**d) State Targeted Response TTC?**

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**

No

**2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus**

**a) Tuberculosis**

No

**b) Early Intervention Services Regarding HIV**

No

**3. Additional Agreements**

**a) Improvement of Process for Appropriate Referrals for Treatment**

No

**b) Professional Development**

No

**c) Coordination of Various Activities and Services**

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>



## Recovery

*The implementation of recovery supports and services are imperative for providing 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 guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. Because mental and substance use disorders are chronic conditions, systems and services are necessary to facilitate the initiation, stabilization, and management of long-term recovery.*

*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 to the greatest extent possible, 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

**b) Required peer accreditation or certification?**

Yes

**c) Block grant funding of recovery support services?**

Yes

**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

**2. Does the state measure the impact of your consumer and recovery community outreach activity?**

Yes

**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 an 1115 Medicaid Transformation Demonstration (MTD) waiver to provide supportive housing and supported employment services to individuals receiving Medicaid and who meet specific risk criteria. Individuals with SMI including youth 16 and up 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 27 randomized, controlled trials.

Homelessness is traumatic, cyclical, and puts people at risk for mental health and substance use disorders. Homelessness also interferes with one's ability to receive services, including services for behavioral health conditions, and jeopardizes the chances for successful recovery. The 1115 MTD 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.

In addition to the Foundational Community Supports, the Housing and Recovery through Peer Services is available to individuals with serious mental illness at risk of exiting or entering inpatient behavioral health programs. The Housing and Recovery through Peer Services (HARPS) program builds on the successes of the Permanent Options for Recovery-Centered Housing (PORCH) project. PORCH provided consumers 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 serious mental illness. 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.

Peer Support services have been a Medicaid reimbursable service since 2005. 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. The Division of Behavioral Health and Recovery (DBHR) is in the process of expanding to include individuals with lived experience in substance use treatment.

#### **4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.**

Starting July, 2019, SUD peer support services will be 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. These services were legislatively mandated and a strategic planning process including many individuals with lived experience assisted in the development of rules and curriculum revisions.

The Housing and Recovery through Peer Services (HARPS) program builds on the successes of the Permanent Options for Recovery-Centered Housing (PORCH) project. PORCH provided consumers 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 serious mental illness. 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. Individuals exiting substance use facilities are eligible for HARPS services and resources.

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 24 of the 39 counties within the state

- 75 women's houses, including one on tribal land
- 34 women with children houses
- 201 men's houses, including one on tribal land
- Nine men with children houses

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 has been the recipient of all four cohorts and the current grant ends January 31, 2019. Total funding for our state is about \$55 million, supporting recovery for more than 30,000 individuals. ATR will no longer be funded by SAMHSA but many of the recovery support services implemented by the ATR initiative will be sustained through SABG or State Opiate Response Grant funds.

Over the more than 14 years of recovery support services funded by ATR, more than 4,300 providers have partnered with ATR to support recovery. Integral to the success of the ATR program, and more importantly the individuals who were supported with ATR funding, are the commitment and support of community partners. Supporting individuals in community reduces isolation, encourages attachment, decreases homelessness, increases rate of employment, and provides stability.

**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.

[Becoming Employed Starts Today \(BEST\) project](#)

[Housing and Recovery through Peer Services \(HARPS\) program](#)

[Housing subsidies through Health Care Authority and Department of Commerce](#)

[Office of Consumer Partnerships](#)

[Oxford Houses of Washington](#)

[Peer Support program](#)

[Supported employment](#)

[Supporting recovery in community](#)

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

In the 2019 Legislative session, 2SHB1394 provided an opportunity for Washington to transform the community behavioral health system by incorporating peer run respite programs. "Mental health peer respite center" means a peer-run program to serve individuals in need of voluntary, short-term, non-crisis services that focus on recovery and wellness. Washington would like technical assistance to develop peer run respite centers that are aligned with best practices throughout the country.

#### **Children and Adolescents M/SUD Services – Required for MHBG**

*MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG 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. 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. For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death.*

*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. 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.*

*According to data from the 2015 Report to Congress 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).*

*Please respond to the following:*

**1. Does the state utilize a system of care approach to support:**

**a) The recovery and resilience of children and youth with SED?**

Yes

**b) The recovery and resilience of children and youth with SUD?**

Yes

**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

**b) Juvenile justice?**

Yes



**c) Education?**

Yes

**3. Does the state monitor its progress and effectiveness, around:**

**a) Service utilization?**

Yes

**b) Costs?**

Yes

**c) Outcomes for children and youth services?**

Yes

**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

**b) Mental health treatment and recovery services for children/adolescents and their families?**

Yes

**5. Does the state have plans for transitioning children and youth receiving services:**

**a) to the adult M/SUD system?**

Yes

**b) for youth in foster care?**

Yes

**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 Children's Behavioral Health Governance Structure, in informing and providing oversight for high-level policy-making, program planning, decision-making, and for the implementation of the T.R. Settlement Agreement and statewide governance oversight of the State Youth Treatment – Implementation (SYT-I) grant and Recovery Supports initiative. In alignment with the Children's Behavioral Health Principles, the Statewide and Regional FYSPRT recommends strategies to provide behavioral health services and supports for children and youth as well as monitor and 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 driven and youth guided, 2) Cultural and linguistic appropriate services and 3) community based services and support the goals of the Washington State system of care:

- 1) Infuse system of care principles 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 children’s behavioral health principles.
- 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:

- Legislative direction for the creation of Behavioral Health Organizations which began in April 2016. Behavioral Health Organizations took lead in integrating Substance Use Disorder services into managed care with mental health services. This process is the first step to full purchasing integration with physical and behavioral health services.
- 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. Access to Care Standards highlights the need to evaluate functional need in all domains.
- Roll out of Washington State’s First Episode Psychosis Initiative, 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.
- 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 Behavioral Health Organization regions. 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 these six youth serving state partners: Rehabilitation Administration-Juvenile Rehabilitation (RA), Department of Health (DOH), Children's Administration (CA), Health Care Authority (HCA), Office of Superintendent of Public Instruction (OSPI), and Developmental Disabilities Administration (DDA).

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.

Contractors are required to implement at least 15 percent Evidence/Research-Based Programs and/or Practices (EBPPs) into the Behavioral Health Organization contracts for children/youth. The required percentage increases yearly with 2017 contractual requirements ending at 30 percent. The intention is by the end of 2019, the percentage of EBPP services for children and youth will be no lower than 45 percent per region.

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 (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 of 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)

#### Suicide Prevention

*Suicide is a major public health concern, it is the 10th leading cause of death overall, with over 40,000 people dying by suicide each year 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. 87*

Please respond to the following:

**1. Have you updated your state's suicide prevention plan in the last 2 years?**

Yes

**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.

- 2019 legislative sessions saw passage of SB 5181 which mandates a 6 month loss of firearms rights for individuals detained for treatment due to "likelihood of serious harm", which takes effect 90 days post session.
- BH Integration efforts across the state have promoted more universal mental health screenings for individuals at primary care settings, including suicide screenings. The Ask Suicide-Screen Questions (ASQ) Toolkit is a free resource for medical settings. The ASQ includes four screening questions that takes 20 seconds to administer. In an NIMH study a "yes" response to one or more of the four questions identified 97% of youth (aged 10 to 21 years) at risk for suicide. By enabling early identification and assessment of young patients at high risk for suicide, the ASQ toolkit can play a key role in suicide prevention.

<https://waportal.org/resources/ask-suicide-screening-questions-asq-toolkit>

**3. Have you incorporated any strategies supportive of Zero Suicide?**

Yes

**4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments?**

No

**5. Have you begun any targeted or statewide initiatives since the FFY 2018 - 2019 plan was submitted?**

No

**Support of State Partners**

*The success of a state's MHBG and SABG 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 SMA 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 justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with M/SUD who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate*

*diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;*

- *The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and SUDs, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;*
- *The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;*
- *The state public housing agencies which can be critical for the implementation of Olmstead;*
- *The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and*
- *The state's office of homeland security/emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in M/SUD needs and/or impact persons with M/SUD conditions and their families and caregivers, providers of M/SUD services, and the state's ability to provide M/SUD services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in M/SUD.*

*Please respond to the following items:*

**1. Has your state added any new partners or partnerships since the last planning period?**

Yes

**2. Has your state identified the need to develop new partnerships that you did not have in place?**

Yes

**If yes, with whom?**

Accountable Communities of Health (ACHs), FCS and Opiate work partners.

**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.**

Washington continues to experience a heightened focus on its public mental health system. The integration of behavioral health services with primary care presents multiple challenges.



As is the case in a great many public behavioral health systems nationally, Washington State is confronted with limited resources to meet the basic needs of its consumers. As we move forward in implementation of changes intended to promote consistency and more equitable access to quality services, we remain aware of potential systemic shortcomings that must be addressed as a priority in order to carry out other intents.

Accordingly, the Division of Behavioral Health and Recovery (DBHR) coordinated efforts and partnered with Aging and Long Term Services Administration (ALSTA) and the Health Care Authority (HCA) to develop a Medicaid 1115 demonstration waiver to add supported housing and employment as Medicaid covered services. The partnership creates a benefit of targeted, supportive housing services for eligible Medicaid beneficiaries. These housing-related services do not include payment for room and board, Medicaid funds will be used to pay for services that help Medicaid beneficiaries get and keep housing. The supportive housing service package includes services that identify and assist individuals in obtaining appropriate housing and provide tenant support to maintain housing, and one-time supports necessary for individuals to avoid institutional settings and to transition into an apartment or home. The supportive housing benefit will not replace existing services currently available to eligible populations.

Supportive housing services will demonstrate the positive effect that safe, secure housing has on people in need:

- Who have experienced chronic homelessness
- Who depend on costly institutional care
- Who depend on restrictive adult residential care/treatment settings
- In-home care recipients with complex needs
- Highest risk for expensive care and negative outcomes

The collaborative partnership between DBHR, ALSTA and HCA also focuses on supportive employment. These services will help people who are eligible for Medicaid and have physical, behavioral, or long-term service needs that make it difficult for them to get and keep a job. It will provide the ongoing services and supports these individuals need, including individualized job coaching and training, employer relations, and assistance with job placement. These services have proven especially effective for certain populations with complex needs and include:

- Individuals with disabling conditions struggling to remain engaged in labor market
- Individuals experiencing significant mental illness, substance use disorder, or co-occurring conditions
- Long-term care recipients with complex needs
- Vulnerable youth and young adults

Similar to the supportive housing benefit, referral to these services must be the result of a needs assessment.

State Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application – Required for MHBG

*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 SABG, 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.*

*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.*

*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.)**

**a) What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment, and recovery services?**

Draft versions of the FY2020-21 block grant were submitted to BHAC for review prior to their July meeting after incorporating commentary from a tribal roundtable in late June. The grant application was discussed at the meeting on July 10<sup>th</sup> and the council members requested additional time to review further. Feedback was collected in the weeks following that meeting, and several of the suggested changes were incorporated into the block grant application.

**b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work?**

Yes

**2. Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?**

Yes

**3. 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 54 percent 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. The council also includes many partners and stakeholders from other state agencies including the Health Care Authority, Children’s Administration, Long Term Care, Developmental Disabilities, Juvenile Rehabilitation, Department of Health, 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.

*Additionally, please complete the Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.*

#### Behavioral Health Advisory Council Composition by Member Type

Type of Membership	Number	Percentage
<b>Total Membership</b>	<b>39</b>	<b>100%</b>
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	7	18%
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	4	10%
Parents of children with SED*	5	13%
Vacancies (Individuals and Family Members)	2	5%
Others (Not State employees or providers)	3	8%
<b>Total Individuals in Recovery, Family Members &amp; Others</b>	<b>21</b>	<b>54%</b>
State Employees	14	36%
Providers	3	8%
Federally Recognized Tribe Representatives	1	3%
Vacancies	0	0%

<b>Total State Employees &amp; Providers</b>	<b>18</b>	<b>46%</b>
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
<b>Total Individuals from Diverse Racial, Ethnic, and LGBTQ Populations</b>	<b>0</b>	
Persons in Recovery from or providing treatment for or advocating for substance abuse services	0	

\*States are encouraged to select these representatives from state Family/Consumer organizations

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

The council is in the process of reviewing the application and the membership