

ORGANIZATION OF THE BEHAVIORAL HEALTH SYSTEM

The Department of Social and Health Services (DSHS) is Washington's largest state agency and houses the majority of the Washington state's social and behavioral health programs. In any given month, DSHS provides some type of shelter, care, protection, and/or support to 2.2 million of our state's 7 million people (http://www.ofm.wa.gov/pop/stfc/stfc2014/stfc_2014.pdf).

The Revised Code of Washington (RCW) Chapter 70.96A identifies DSHS as the Single State Agency (SSA) for planning and delivery of substance abuse prevention and treatment services.

DSHS, as designated in RCW 71.24.05, is the State Mental Health Authority (SMHA) in developing the state mental health program for (i) persons with acute mental illness; (ii) adults with chronic mental illness and children who are severely emotionally disturbed; and (iii) persons who are seriously disturbed, including parents who are respondents in dependency cases.

DSHS has eight direct service administrations including the Behavioral Health Administration (BHA). All administrations are committed to the single mission: to transform lives. The BHA focuses on transforming lives by supporting sustainable recovery, independence, and wellness. BHA will improve the safety and health of individuals, families, and communities by providing leadership in establishing and participating in partnerships. Together we will decrease poverty, improve the safety and health status of citizens, increase educational and employment success, and support people and communities in reaching their potential.

The BHA provides prevention, intervention, inpatient treatment, outpatient treatment and recovery support to people with addiction and mental health needs. Over the 2015 calendar year – pre BHO implementation (January 1, 2015 – December 31, 2015):

- 174,382 clients participated in mental health treatment.
- 49,742 clients participated in substance use disorder treatment.
- 17,494 clients received direct services with community strategies reaching over 100,000 clients with substance use disorder prevention activities.
- 448 clients participated in pathological and problem gambling treatment.

BHA includes the Division of Behavioral Health and Recovery (DBHR), the Office of Forensic Mental Health Services, and the state psychiatric hospitals. BHA's core services focus on:

- Individual Support – Providing support to clients who face challenges related to mental illness or substance use disorder and pathological/problem gambling, including the prevention of substance use disorder and mental health promotion.
- Health Care Quality and Costs – Designing and implementing integrated care systems in conjunction with other DSHS administrations and the Health Care Authority to improve client health outcomes and contain health care costs.
- Administration – Providing management infrastructure to support administrative functions such as accounting, fiscal, forecasting, contracting, and information technology for BHA.

BHA operates three state psychiatric hospitals. Eastern State Hospital and Western State Hospital deliver high-quality inpatient psychiatric care to adults who have been committed through the civil or criminal court system for treatment and/or competency restoration services. The third hospital, Child Study and Treatment Center, provides high-quality inpatient psychiatric care and education to children ages 5 to 17 who cannot be served in less restrictive settings in the community due to their complex needs. The three state hospitals have a combined inpatient capacity to serve 1,100 patients. In addition to providing inpatient services, the hospitals also provide outpatient forensic services for individuals who are waiting for an evaluation or for whom the courts have ordered an out-of-custody competency evaluation.

BHA provides support for Mental Health, Substance Use Disorder, and Pathological and Problem Gambling Services. Chris Imhoff is the director of the Division of Behavioral Health and Recovery and, as such, serves as the director for the Single State Agency (SSA) for the Substance Abuse Prevention and Treatment block grant and the State Mental Health Authority (SMHA) for the Community Mental Health Services block grant.

DBHR manages state and federal funds that support the majority of public behavioral health services in Washington State. This includes program policy and planning, program implementation and oversight, provider certification, fiscal and contract management, Management Information Systems (MIS), and comprehensive program outcome studies.

Washington State leverages partnerships and local dollars to meet the broad behavioral health needs of its citizenry. DBHR uses several fund sources (State, federal, provisos, etc.) to support Substance Use Disorder (SUD) prevention and Mental Health (MH) promotion (including targeted prevention services, community-based environmental strategies, and behavioral health promotion strategies), and a broad system of treatment options. Additionally, DBHR sponsors recovery supports and champions the development of system of care networks.

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

- Building on a continuum of services including, prevention, intervention, treatment and recovery support, which incorporate evidence-based programs and practices whenever possible.
- Redesigning the children's mental health system to expand wraparound services throughout the state.
- Developing an innovative program to address transition age youth who have experienced a first-episode psychosis.
- Integrating the purchasing of substance use disorder and mental health treatment services into a single managed care contract.
- Expanding to full integration with primary care by 2020 with pilot projects in between until full implementation.

The Unified Block Grant is an important driver to assist Washington State and BHA to move toward an integrated Behavioral Health System of Care. DBHR will use Block Grant funds to initiate the plan for

change. 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 and children who are serious emotional disturbed and their families.
- Services for persons with or at risk of substance use and/or mental health disorders (priority focus on intravenous drug users, and pregnant and parenting women with substance use and/or mental disorders).
- Services for persons with tuberculosis who are in treatment for substance abuse.

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

- Children, youth, adolescents, and youth-in-transition with 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.
 - Military service members, veterans, or military family members.
- Members of traditionally underserved, including:
 - American Indian/Alaska Native population
 - Racial/ethnic minorities.
 - LGBTQ populations.
 - Persons with disabilities.

As we assess the Washington state behavioral health service 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 from several lenses:

- The contracting of the state's public behavioral health,
- The transition to integrated purchasing of services through managed care contracts,
- Data informed decisions based on a statewide needs assessment,
- An overview of the continuum of care offered by Washington State,
- Efforts made to continue to develop the workforce,
- The strengths and needs of the behavioral health system ,
- Descriptions of block grant required programs.

We will also describe specific needs for behavioral health in the state. Throughout our block grant plan, we incorporate the voices of persons with lived experience, tribes, and other system partners.

CONTRACTING OF THE PUBLIC 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) Fully Integrated Managed Care 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).
- 2) 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.

The first task for the state was to establish Regional Service Areas (RSAs) for all federal and state behavioral health care purchasing which began April 1, 2016. Each RSA contained a sufficient number of Medicaid lives to support full financial risk managed care contracting for services, be composed of counties that are contiguous with each other, and reflect natural referral patterns and shared service resources. As the state continues to expand Fully Integrated Managed Care (FIMC), other RSAs will become part of the fully integrated delivery system. These managed care entities contract with service providers to deliver integrated care in each RSA.

Behavioral health care contracts for services to Medicaid beneficiaries are with the BHOs while physical health services are under a separate managed care contract with MCOs or provided through a fee for service programs. The contracts between DSHS for the provision of outpatient substance use disorder services (SUD) on a fee-for-service basis, and the direct contracts between DSHS and SUD residential treatment services, were terminated effective March 31, 2016 with the exception of FFS contracts for services delivered to the American Indian/Alaska Native (AI/AN) population for SUD. The HCA is contracting with MCOs (for clients enrolled in Apple Health managed care) and PIHPs (for clients who receive physical health care outside of Apple Health managed care). The HCA is responsible for the full continuum of physical and behavioral health services for clients in “integrated” regions.

With AI/AN population being carved out of the BHO process, providers across the state can elect to serve the AI/AN population through a fee for services process. Currently over 100 providers have offered to provide SUD treatment services with the AI/AN population.

Individuals that self-identify as AI/AN can be served within the FFS programs statewide from any provider that is on the approved DBHR provider list. All levels of SUD treatment services are covered residential, intensive outpatient, outpatient, withdrawal management, and assessments.

In the Southwest Region of the state, AI/AN resident’s coverage for SUD coverage will be administered through the managed care process by the Health Care Authority.

Behavioral Health Organizations

As Prepaid Inpatient Health Plans (PIHPs), the BHOs contract for direct services with local providers to provide an array of behavioral health services, 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 quality service delivery, which is age 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.

The BHOs also work cooperatively with Apple Health MCOs to ensure coordinated care for enrollees. Apple Health is Washington's Medicaid-funded managed care program, which covers a full array of medical services as well as a mental health benefit for those who do not meet the Access to Care Standards for mental health services provided by the BHOs.

Behavioral Health Services Only

In the FIMC region, HCA contracts with at least two current Apple Health managed care entities, selected through a competitive Request for Proposal (RFP) to deliver integrated health care as PIHP entities.

Most Medicaid enrollees, including all current Apple Health managed care enrollees, in the FIMC region, enrolled in the Apple Health Fully Integrated Managed Care program. The remaining enrollees are mandatorily enrolled in the Behavioral Health Services Only (BHSO) component of the FIMC integrated contracts.

State Hospitals

Funding for State hospitals is legislatively defined "funded capacity" or census and are at risk of over-expenditure if patients are admitted beyond the funded capacity, even though patients admitted under criminal statutes cannot be turned away. As state hospital civil capacity is an integral part of the community's resource for treating persons with mental illness, the BHOs are responsible for maintaining their use of state hospital capacity within contractual limits.

Tribal Contracting

State Tribal Agreements and/or Contracts

DBHR continues to provide funding opportunities for tribes. Approximately \$16 million is available during this biennium to support substance use disorder prevention and treatment programs and \$255,000 in state funds have been provided to enhance mental health services administered by our tribes.

Consolidated Contracts with DSHS are for services provided in a tribal behavioral health program. These contracts provide financial support for the 29 federally recognized tribes for culturally based treatment services and/or prevention activities. Tribal programs provide services mostly to the tribal populations, but at the discretion of the tribe can serve nontribal members as well.

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. In 2005, an additional \$1.4 million dollars was added to the tribal allocations in conjunction with treatment expansion. Through a consultation effort, led by the DSHS Secretary, the tribes determined they would like the funds to be distributed using a 30/70 formula. This meant that 30 percent of the additional dollars were split evenly amongst all tribes and 70 percent distributed on a per capita basis determined by Indian Health Service's service area population figures for each individual tribe.

Tribal substance use disorder prevention and mental health promotion programs are specific to each tribe's local needs, culture and traditions. Tribes select evidence-based programs or develop tribal prevention programs that best serve their members and surrounding community members. Tribes develop an annual prevention program plan with the assistance of DSHS's Office of Indian Policy (OIP) and DBHR.

Medicaid - Federal Memorandum of Agreement (MOA) (IHS Encounter Rate)

Under the terms of the federal MOA, tribally owned clinics authorized through the Indian Health Services, receive reimbursement at 100 percent of the encounter rate for outpatient substance use disorder treatment and mental health services to eligible American Indian clients. Tribal programs receive half the encounter rate for outpatient services to non-native clients. In conjunction with the HCA, DBHR offers technical assistance, training and consultation to tribal FQHCs and 638 Mental Health Programs on billing procedures and Medicaid regulations.

Prevention Services

DBHR prioritizes funding for scientifically proven strategies to prevent substance use, 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 client service contracts.
- Community-based organization contracts.
- Interlocal contracts.
- Consolidated Intergovernmental Agreements (IGA) with Washington State Federally Recognized tribes through the Office of Indian Policy (OIP).
- Personal service agreements made for services such as training for workforce development and capacity building.

Most services provided are structured drug and alcohol prevention curriculum for youth (including drug-free activities) and parenting classes for adults. Services also include community organizing efforts and environmental strategies directed at prevention of substance use, policy change, drug education campaigns, and drug-free activities.

Washington State's Community Prevention and Wellness Initiative (CPWI) is a strategic, data-informed, community coalition model aimed at bringing together key local stakeholders to provide the needed 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 the Superintendent of Public Instruction (OSPI) for the placement of prevention/intervention specialists in schools to provide universal, selective, and indicated prevention and intervention services. Prevention/intervention specialists 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 prevention/intervention specialists also practice 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 Prevention Intervention Specialist (PIs). Tribes are using PIs to implement Project SUCCESS. Project SUCCESS is a model for PIs used statewide in Washington. Funds support PI staff time in a school to provide both prevention and intervention services. A tribal PI will be presenting about Project SUCCESS at DBHR's Tribal Prevention Learning Community meeting. More detail is available in the [Project SUCCESS link](#).

ADULT BEHAVIORAL HEALTH SYSTEM

Mental Health

Behavioral Health Organizations, 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. 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.

Each BHO contracts with provider groups and community mental health agencies. Each BHO network serves all Medicaid enrollees within its geographical area—including American Indians and Alaskan Natives (AI/ANs). BHO crisis services are available to all residents, without regard to funding or Medicaid eligibility.

The BHOs 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, crises 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 accept less restrictive alternatives to be involuntarily detained.

Voluntary and involuntary community inpatient services for adults provided in community hospital psychiatric units and in freestanding non-hospital evaluation and treatment facilities (E&Ts) authorized by the Behavioral Health Organizations (BHOs). Some inpatient resources are certified for short-term (up to 17 days) ITA services.

Discharge planning focuses on aftercare, crisis resolution, and treatment planning may consist of a period of authorization for high intensity services. Longer terms for adult Involuntary Treatment Act services (court ordered 90-day and 180-day commitments) are provided by the two state-operated adult psychiatric hospitals – Eastern State Hospital and Western State Hospital.

Approximately 70 percent of individuals at the state hospitals are under civil commitment orders. The remaining 3percent receive court-ordered forensic services. These include:

- Evaluation of individuals for competency to stand trial.
- Treatment to restore competency for those deemed not competent to stand trial.
- Ongoing treatment for individuals found to be not guilty by reason of insanity.

Substance Use Disorder Treatment

DBHR provides guidance and program oversight so that a full array of quality treatment services are available to patients by approved providers statewide. Treatment plans, based on results from an assessment, are individualized and designed to maximize the probability of recovery.

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. For most people treatment services are part of their health insurance

Intensive residential and outpatient treatment for substance use disorder includes counseling services and education. Some patients receive only outpatient treatment. Other patients transfer to outpatient treatment after completing intensive residential services. Relapse prevention strategies remain a primary focus of counseling.

Withdrawal management (also known as detoxification) services assist patient's withdrawal from alcohol and other drugs. Acute withdrawal management occurs in a medical setting and provides medical care. Sub-acute withdrawal management occurs in a home-like environment in which patients may self-administer medications ordered by a physician for use while the patient is in the facility.

There are currently three types of residential substance use disorder (SUD) treatment 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. 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 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 slots. 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 (MAT) is pharmacotherapy for substance use disorder. It combines pharmacological intervention with counseling and behavioral therapies. This is also known as Opiate Substitution Treatment (OST). These treatment programs must address an array of comprehensive medical, vocational, employment, legal, and psychological issues or provide referrals to community based programs that have the expertise to address these issues. Currently, there are 22 clinics offering OST services and 16 of those sites offering public-funded services include two tribal programs.

DBHR recognizes the following MAT medications for the treatment of addictions: Methadone; Buprenorphine (Suboxone); Acamprosate (Campral); and Naltrexone (Vivitrol or ReVia). These medications must be prescribed by a physician. Medicaid payment authorization is also required for utilization of this type of treatment.

Washington has codified statutes aimed at protecting individuals and the community by providing for involuntary substance use disorder treatment. Involuntary commitment is the mandatory placement in a treatment facility for an individual who presents a likelihood of serious harm or gravely disabled because of a substance use disorder. RCW Chapter 70.96A.140 authorizes a designated substance use disorder specialist to investigate and evaluate allegations that a person is incapacitated because of a substance use disorder. If it is determined that the facts are reliable and credible, the specialist may file a petition for commitment of such a person with the superior or district court. Two long-term care facilities, Pioneer Center North in Sedro-Woolley (PCN) and Pioneer Center East in Spokane (PCE) receive the majority of the referrals. Some individuals may also be referred to other intensive inpatient or long-term residential treatment facilities.

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

CHILDREN AND YOUTH BEHAVIORAL HEALTH SYSTEM

Mental Health

Behavioral Health Organizations (BHOs), through contracts with community behavioral health agencies, provide an array of services to children and youth with serious emotional disorders (SEDs) who meet the Access to Care standard (diagnosis and level of functional impairment) and standardized medical necessity criteria. 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, and stabilization services.

There are two freestanding evaluation and treatment centers in Kitsap and Yakima counties providing involuntary treatment services for youth. In addition, three community hospitals provide acute psychiatric care for youth. Longer term inpatient mental health services for children and youth, both voluntary and involuntary, are provided through the centralized Children's Long-Term Inpatient Program (CLIP). The CLIP facilities include the Child Study and Treatment Center, a 47-bed state-run psychiatric hospital, as well as an additional 37 beds at three CLIP inpatient residential facilities. Contracts between CLIP and each BHO detail the responsibilities for the resource management of these 84 beds.

Additionally, in July 2014, Washington State embarked on a process to improve access to, and the effectiveness of, intensive individualized behavioral health services delivered in the home or community for youth affected by serious emotional disturbances. The state, through the community mental health system, began rolling out a new program model that will be available within every county across the state by June 2018. This new program model, Wraparound with Intensive Services (commonly called WISe) meets the complex behavioral health needs of children and youth on Medicaid up to 21 years of age. The goal of WISe is to provide services that allow youth to live and thrive in their homes and communities, while avoiding or reducing costly and disruptive out-of-home placements.

WISe offers a higher level of care than traditional mental health services through these core components:

- **The Time and Location of services:** WISe is not office-based. Services are in locations and at times that work best for the youth and family, such as in the family home and on evenings and weekends.
- **Team-based Approach:** Using a wraparound model, WISe relies on the strengths of an entire team to meet the youth and family's needs. Intensive care coordination between all partners and team members is essential in achieving positive outcomes. Each individual team include the youth, family members, natural supports, a therapist, a youth partner and/or family partner, and members from other child-serving systems that are involved in the youth's life. Other team members could include family friends, school personnel, a probation officer, a religious leader, a chemical dependency counselor, or a coach/teacher. The team creates ONE Cross-System Care Plan that identifies strategies and supports, using the youth and family's voice and choice to drive their plan.
- **Help during a crisis:** Youth and families have access to crisis services any time of the day, 365 days a year. Youth receive services from an individual who is familiar with the family and their individualized crisis plan. Whenever necessary, this includes face-to-face interventions at the

location where the crisis occurs.

In addition to WISe, in August 2015 Washington launched another intensive care coordination program using SAMHSA's set-aside Community Mental Health Block Grant funds. The Coordinated Specialty Care (CSC) program, New Journeys, is for clients 15-25 who are experiencing their first episode of psychosis. New Journeys will expand to two additional demonstration sites in July 2016. These three sites will form the New Journeys Network in Washington State. New Journeys will be under the direction of the University of Washington (UW) Department of Psychiatry and Behavioral Sciences. The UW will oversee all aspects of implementation, including program start up, training, ongoing consultation, and coordination and planning between the demonstration projects and DBHR.

A mental health benefit, under the HCA fee-for-service (FFS) or managed care systems, is available for children and youth under 21 who do not meet the Access to Care standards. Under these systems, a child/youth can receive mental health treatment, as medically indicated.

Substance Use Disorder Treatment

Access to substance use disorder (SUD) treatment services for youth begins with an assessment at a local outpatient or residential facility. Medical necessity must be met to receive services. For SUD services, the two medical necessity criteria are:

- The individual has a SUD as determined by a Chemical Dependency Professional (CDP), or a Chemical Dependency Professional Trainee (CDPT) under the supervision of a CDP, in a face-to-face assessment in accordance with WAC 388-877 and 388-877B. The diagnosis must be included in the list of SUD Covered Diagnoses.
- Documentation of the American Society of Addiction Medicine (ASAM) multidimensional assessment of the individual's risk(s), impairment(s) and corresponding need(s). Additional medical necessity criteria are included in ASAM criteria.

The age of consent for outpatient substance use disorder services is age 13, meaning youth may independently seek treatment services at age 13. A parent or guardian may also bring their youth to a certified treatment agency for an assessment to determine if symptoms meet medical necessity (per ASAM) for substance use disorder treatment (RCW 70.96A.250). The consent of the minor for this assessment is not required; however, consent is required for treatment services.

State certified, youth serving, outpatient programs generally provide substance use disorder assessments and alcohol-/drug-free counseling for adolescents ages 10 through 17 (but young adults ages 18-20 or children under 10 may be served in youth agencies if developmentally appropriate, with approval of their regional Behavioral Health Organization care manager). Family members of youth can receive collateral and family support services. Outpatient treatment programs are designed to stabilize, treat, counsel, and build family and social support systems to promote personal development and recovery.

Depending upon the level of care needed, individual programs may provide more intensive interventions and services. Youth residential substance use disorder services are composed of multiple modalities, including withdrawal management and crisis stabilization services.

The purpose of withdrawal management and crisis stabilization services for youth is to provide a safe, temporary, protective environment for at-risk/runaway youth who are experiencing harmful effects of intoxication and/or withdrawal from alcohol and other drugs, in conjunction with emotional and behavioral crisis, including co-existing or undetermined mental health symptomatology.

Youth appropriate for Recovery House services have completed residential substance use disorder treatment, and are transferred to a Recovery House when they cannot immediately live with their legal guardians, parents, foster parents, other relatives, or other out-of-home placement. Recovery House programs provide structure and supervision, continued treatment with an emphasis on recovery and abstinence, and improvement of living skills, including education and employment skills. The programs also provide access to community support systems and youth participation in age-appropriate activities.

Youth who may be experiencing immediate and life threatening consequences of substance use disorder, and who meet the incapacity criteria described in RCW 70.96A.140, may require involuntary commitment. Youth must meet Involuntary Treatment Act (ITA) requirements and be evaluated by a Designated Crisis Responder. The responder must assess whether a youth, as a result of the use of substances, has impaired judgment and is incapable of making a rational decision for treatment, and presents a likelihood of serious harm to another person or to property; or that the youth has been admitted to detox or substance use disorder treatment twice in the past year. DBHR has contracted residential “secure” facilities, but does not have “locked” ITA facilities. Historically, most ITA youth have “stipulated” (voluntarily been admitted after an ITA admission) upon, or shortly after admission, as treatment staff work to engage them in treatment.

Treatment services must be culturally competent; this includes providing an environment in which youth and family from diverse cultural backgrounds feel comfortable discussing their cultural beliefs and practices in the context of negotiating treatment options.

AN OVERVIEW OF THE CONTINUUM OF CARE

DBHR includes services and program support 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. The co-location of mental health and substance use disorder within a single division has been a significant strength in Washington State as we move forward in implementing health care reform.

Prevention/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).

Legislation

Initiative 502 defines and legalizes small amounts of marijuana-related products for adults 21 and over, taxes it, and designates the revenue for healthcare and substance use disorder prevention and treatment. As noted at RCW 69.50.101, cannabis is a Schedule 1 controlled substance under federal law and subject to federal prosecution under the doctrine of dual sovereignty. Possession by anyone younger than 21, possession of larger amounts, and the growing of unlicensed or unregulated marijuana remains illegal under state law. For the 2015-2017 Biennium, DSHS/DBHR received specific appropriations for services enhancements and new programs. Additionally, portions of the funds replaced services previously funded with other state or federal dollars. No appropriations were made prior to the 2015-2017 Biennium.

Initiative 692 permitted the medical use of marijuana by patients with certain terminal or debilitating conditions. Non-medical use of marijuana would be prohibited. Physicians advised patients about the risks and benefits of the medical use of marijuana. Qualifying patients and their primary caregivers are protected from prosecution if they possessed marijuana solely for medical use by the patient. Additional detail on the restrictions and limitations are in the initiative. In 2015, Washington passed SB5519, the comprehensive marijuana reform act that combined the state regulatory system for medical and recreational marijuana.

Treatment

Mental Health

DBHR funds the BHO 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 including Multi-systemic Therapy (MST), Wraparound and Multi-dimensional Treatment Foster Care (MDTFC), 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 involuntary treatment is indicated, either a designated chemical dependency specialist or a designated mental health counselor investigate and evaluate facts alleging that a person would be better served through the Involuntary Treatment Act. If the designated chemical dependency specialist determines that the facts are reliable and credible, the specialist may file a petition for commitment of such a person with the superior or district court. The designated mental health counselor will determine if an individual manifests mental health behaviors and symptoms that suggest the individual is at risk for harm to self or others or is gravely disabled without a mandatory treatment intervention.

Substance Use Disorder

Substance use disorder assessments use the American Society of Addiction Medicine (ASAM). This assessment determines consumer need and the corresponding level of care or modality of service that meets that need. Outpatient or residential treatment can be the first level of care, depending on patient need per ASAM. Certified treatment agencies provide the outpatient substance use disorder services in local communities. If the consumer needs residential substance use disorder treatment, referral is made to Washington State's statewide residential treatment system.

DBHR is a recipient of the State Adolescent Treatment Enhancement and Dissemination (SAT-ED) and the State Youth Treatment – Implementation (SYT-I) grants. These grants provide the opportunity for enhanced treatment and recovery services for youth (ages 12 to 18) who have a substance use disorder diagnosis and youth who have a co-occurring substance use disorder and mental health disorder diagnosis (COD).

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).

Recovery Support Services

DBHR recognizes recovery support services as important adjuncts in helping ensure individuals in recovery from substance use disorder or mental illness can move toward healthy lifestyles and return to active, productive lives. Examples include individualized support systems, housing, supported employment, case management, peer supports, and specialized programs. It is imperative to embed recovery services within a system of care in which persons with lived experience can identify realistic goals, prioritize steps to meet goals, and select services to aid them on their path to recovery.

The Access to Recovery (ATR) grant provides funding for recovery services to individuals and families in nine Washington state counties. These services include mental health counseling, medical and dental care, preventive services for family members, transportation, employment, and housing assistance. The services are consumer driven and self-directed, with persons with lived experience selecting support services from a menu of services that they believe will aid them on their path to recovery.

Housing

DBHR supports the efforts of over 258 Oxford Houses in Washington State (approximately 2,141 beds based on each house having 8.3 residents). The Oxford Housing provided sober housing to 8,564 individuals last biennium. The average stay is approximately 12 to 24 months; there is no limit on length of stay. The Oxford House, based on the concept of promoting alcohol/drug recovery, are democratically run, self-supporting, and drug-free homes. Tenants pay their share of the rent and utilities, which averages \$380/month. The houses are gender specific and some homes at welcome children. Each house represents a remarkably effective and low-cost method of preventing relapse. In Washington State, six outreach workers provide direct services, identify the need for new Oxford Houses, find homes to lease, negotiate with property owners for new leases, and recruit initial residents. Oxford House tenants receive living skills training, as well as training on how to establish new chapters and how to keep the Oxford Houses a safe place of recovery.

The Permanent Options for Recovery-Centered Housing (PORCH) project provides the evidence-based practice Permanent Supportive Housing (PSH). The target population is adults, who are homeless, inappropriately housed, exiting psychiatric hospitalization, or at risk of becoming homeless due to serious mental illness (or co-occurring mental and substance use disorders). The PORCH project is a partnership between DBHR, two BHOs, and local mental health and housing provider agencies. The project provides PSH throughout one urban and two rural Washington counties, serving 100 to 150 individuals per year. The PSH project teams provide housing-related support services and other assistance through certified peer specialists and assist in the overall implementation of the project, including outreach to perspective participants, the community, partners, and stakeholders. Services funded under this project are married with housing subsidies and vouchers from community resources. Fidelity reviews, conducted annually, adhere to the principles of the SAMHSA evidence-based practice model.

Another initiative supporting recovery in the past ten years has been Washington State's Project for Assistance in Transition for Homelessness (PATH) program. The PATH program does outreach to chronically homeless individuals who normally do not access social services and resources in the community. PATH programs assist individuals in accessing housing, mental health services, substance use disorder treatment, disability benefits, and other services to stabilize them and facilitate recovery. Persistent and consistent outreach and providing services at the client's pace are important steps to engage people with serious mental illness who are homeless.

These projects are strategies in the Housing 3000: Chronic Homeless Policy Academy strategic plan to end chronic homelessness. Washington State's Housing 3000 Policy Academy, which focuses on high-impact chronic homelessness solutions and interventions, is part of the Washington Inter-Agency Council on Homelessness. The Policy Academy, sponsored by SAMHSA, continues to meet on a monthly basis to review the action steps and progress towards ending chronic homelessness.

The Policy Academy developed a strategic plan, which has identified three key goals:

- Prevent households from falling (back) into homelessness by expanding the use of mainstream resources for persons in permanent supportive housing, taking advantage of the Affordable Care Act and Medicaid reform.
- Expand the inventory of resources around permanent supportive housing and rapid re-housing for households experiencing chronic homelessness.
- Tailor homeless programs to homeless households' needs by leveraging mainstream systems toward targeted engagement and supportive services, especially to increase housing retention among hard-to-serve populations.

One of the strategies to prevent chronic homelessness is based on a report from Washington State's Research and Data Analysis. The *Housing Status of Individuals Discharged from Behavioral Health Treatment Facilities* (Ford Shah, M., Black, C., Felver, B. 2012) reported that nearly half of the clients discharged from residential chemical dependency (CD) treatment facilities and 30 percent of those discharged from state mental health hospitals are homeless in the year following discharge. Less than one in five of those in need received housing assistance. DBHR designed an intervention funded by the legislature in 2014 called Housing and Recovery through Peer Services (HARPS). The HARPS program will build from the success of the Permanent Options for Recovery-Centered Housing (PORCH) project. Three supportive housing teams with each team consisting of a MHP professional and two certified peer counselors will provide supportive housing services to individuals exiting or at risk of entering inpatient behavioral health settings. In addition, \$1,500,000 in state funding is budgeted to provide housing 'bridge' subsidies for an estimated 1000 individuals across the three sites. The 'bridge' subsidy may include application fees, security deposits, utilities assistance, and rent.

Employment

Medicaid infrastructure funding helps supported employment programs. DBHR works with two national employment consultation firms (Advocates for Human Potential and the Institute for Community Inclusion) to provide technical assistance for communities interested in improving employment outcomes. Participating communities include approximately 65percent of the public mental health persons with lived experience in the state.

Supported employment services are provided in accordance with the SAMHSA research showing that 70 percent of adults with serious mental illness desire work (Mueser et al., 2001; Roger Et al., 2001). Approximately 60 percent of consumers can be successful at working in the community when using supported employment services (Bond et al., 2001). In June 2010, the Washington State Institute for Public Policy (Burley, M., Mayfield, J., 2010) published a report entitled *Factors Related to Employment and Housing Outcomes of Public Mental Health Consumers in Washington State*. The study concluded that consumers who received supported employment services were 51 percent more likely to be employed in the two years following treatment.

The Washington State Olmstead Policy Academy on Employment developed a strategic plan to improve the employment rate of individuals with significant behavioral health issues. The plan includes action steps in the areas of financing supported employment services, workforce development, and community education including educating the individuals themselves.

Mental Health Block Grant funding helps promote employment as part of recovery and uses supported employment programs to achieve higher fidelity towards this evidence-based practice. DBHR works with two national employment consultation firms (Advocates for Human Potential and the Institute for Community Inclusion) to provide technical assistance for communities interested in improving employment outcomes.

The Temporary Assistance for Needy Families (TANF) Supported Employment Pilot program helps individuals with serious mental illness obtain and maintain competitive employment. The pilot program focuses on serving individuals with co-occurring mental health and substance use disorder issues that receive TANF with a subset of individuals who are homeless or at risk of becoming homeless in Snohomish and Skagit Counties. DBHR implemented the pilot in partnership with the Economic Services Administration and community mental health service providers. Under the pilot project, Sunrise Community Mental Health, a certified and licensed agency in the North Sound Behavioral Health Organization, is providing evidence-based practice supported employment services also known as Individual Placement and Support (IPS) services. The Research and Data Analysis Division of DSHS (RDA), is monitoring program enrollment and participation. Baseline characteristics tracked for TANF Supported Employment pilot participants and changes in participant employment, service use and other key outcomes following program enrollment.

The Becoming Employed Starts Today (BEST) project transforms service delivery by promoting sustainable access to evidence-based supported employment. BEST provides consumers with meaningful choice and control of employment and support services. BEST uses peer counselors to reduce unemployment and support the recovery and resiliency of individuals with serious mental illness including co-occurring disorders. DSHS secured the \$3.9 million federal grant from the SAMHSA Center for Mental Health Services. The grant will provide services to 450 people over five years. Grant Mental Health in the Spokane Regional Support Network and Columbia River Mental Health in the Southwest Washington Regional Support Network will implement the project, known as Washington Becoming Employed Starts Today (BEST). Individuals with behavioral health issues can access an approach to vocational rehabilitation known as supported employment (SE). This evidence-based practice adopted

by SAMHSA assists individuals to obtain competitive work in the community and provides the supports necessary to ensure success in the workplace

DBHR works with two national employment consultation firms (Advocates for Human Potential, the Washington Business Alliance and the Institute for Community Inclusion) and the Washington Business Alliance to provide technical assistance for communities interested in improving housing and employment outcomes and achieving high fidelity to the SAMHSA EBP models. Technical assistance and training provides information on how to explore diversification of funding for employment services through the Social Security Administration's Ticket to Work Program. Participating communities include approximately 65% of the public mental health consumers in the state. DBHR is working with the University of Washington to increase the program participants' skill level and use of Motivational Interviewing by employment specialists, certified peer specialists, and peers from consumer operated services in King, North Sound, OptumHealth-Pierce, and Salish BHOs

DBHR facilitates the provision of services through drug courts for individuals with a substance use disorder or mental health problems who are involved with the criminal justice system. DBHR provides funds to provide alcohol and drug treatment services to offenders who are under the supervision of the courts (either through a formal drug court, per RCW 2.28.170, or with a locally specified arrangement where the individual is under the supervision of a county/tribal court). Based on a 2001 Washington State Institute for Public Policy (WSIPP) study, treatment coordinated with court supervision is a cost-effective tool in reducing substance abuse recidivism among offenders.

Programs designed to train and empower persons with lived experience (adults, families raising children with complex needs and youth) are provided by DBHR. We sustain and support empowerment of families through peer-based training for families and caregivers. Similarly, we support youth speaking out for youth. Block grant funding supports the continued development of a statewide youth organization (Youth 'n Action) which coordinates with groups across the state. As well as several clubhouses and adult consumer organizations.

DBHR continues to develop infrastructure to support system of care approaches, particularly wraparound and Wellness Recovery Action Plan (WRAP). Ongoing activities include family-to-family networking and the Community Connectors Training that brings families of children with complex needs together to develop sustainable community resources and connections. The CLIP (Children's Long-term Inpatient Program) Parent Training provides training and support for families with children hospitalized in psychiatric residential treatment facilities.

The Office of Consumer Partnership (OCP) in DBHR expanded from a one-person staff to a team of five who have various types of experience/perspectives as persons with lived experience of behavioral health systems in the state. The members provide voice for children and adult mental health and substance use disorder 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 persons 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 Certified Peer Counseling and Wellness Recovery Action Plan training
- Promoting recovery values statewide through DBHR leadership and involvement in behavioral health systems and the community.

OVERALL STRENGTHS OF THE BEHAVIORAL HEALTH SERVICES IN WASHINGTON

DBHR positioned itself for the major changes to come in the health care system. Senate Bill (SB) 5732 and House Bill (HB) 1519 passed by the 2013 legislature. SB 5732 defines system outcomes for the publically funded behavioral health system – mental health and substance use disorder services. HB 1519 reinforces those same outcomes by applying them to the publically funded medical and long-term care systems as well, with performance measures related to the outcomes adopted and applied across all of these systems.

Washington State emphasizes data driven decision-making for assessment, care coordination, and service implementation. A close collaborator of DBHR, the Research and Data Analysis (RDA) Division of DSHS, 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 persons with lived experience with significant 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 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, identifying gaps in their medication fills 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, long term care) associated diagnoses, pharmacy, and assessments from both Medicaid and Medicare sources (for those clients eligible for both).

NEEDS OF WASHINGTON STATE'S BEHAVIORAL HEALTH SYSTEM

Continuum of Care

We understand the need to work towards improved cross-system collaboration in order to improve outcomes for persons with lived experience and families. This includes better ties between prevention/treatment services and primary care, and better integration between behavioral health and primary care settings. This requires improved collaboration between systems, including education, criminal justice, child welfare, addictions, and mental health. We strive to reduce barriers and provide multiple avenues for individuals to travel on their road to wellness and recovery.

One of the gaps in the state's behavioral health system, both for adults and for children, is the need for adopting and fully implementing an integrated system of care approach with common outcomes and measures. This applies to services that originate at either the mental health or substance use disorder "door." The complexity of describing these systems illustrates the difficulty a consumer or family might have navigating the system for needed care. As we focus on moving our behavioral health system towards the paradigm of wellness and recovery, we need to change from being illness-based to proactive and strength-based starting with our vocabulary and mental models.

There are also gaps in the identification of people outside of our system who need early intervention--- youth who have dropped out of school, young adults not in college or vocational settings, and transition-aged youth who often experience the onset of mental illness.

Providers

There are several challenges facing the provider systems in Washington State. The first of these is purely an issue of capacity. We are unable to develop the necessary prevention/intervention/health promotion that our research suggests would be optimal. With the greatly increased size of the Medicaid-eligible population, there is considerable need to expand system capacity, to focus on workforce development, and to better integrate our systems.

Washington has a significant shortage of community inpatient psychiatric beds. In August 2014, the state Supreme Court, under a ruling that became effective December 26, 2014 struck down the practice of temporarily placing psychiatric patients in non-mental health treatment facilities, such as community hospital emergency rooms without access to appropriate mental health treatment – known as psychiatric boarding. Revisions in the WAC 388-865-0526 Single Bed Certification expanded the scope of the use of this certification allowing a consumer to receive services from a facility that is not currently certified. Consistent with the court's decision, DSHS filed a regulation on December 19, 2015, that defines those situations in which a single bed certification is allowable. All of the situations defined in statute require appropriate mental health care provide an individualized plan of care by a facility that is willing and able to provide services under a single bed certification.

The state is continuing to develop additional certified evaluation and treatment beds for persons meeting involuntary treatment criteria in addition to forging stronger working partnerships with community hospitals and mental health providers to deliver appropriate mental health care in a consumer's home community. DSHS has also committed to submitting a funding request to the

Legislature for a tribal evaluation and treatment center. This recommendation from the Tribes was to help meet the needs of AI/ANs.

There is a particular need for services and providers in rural locations around the state. Even as we consider new modalities of service (e.g., tele-health), there are logistical and structural problems to solve. There is a need to include outreach in other settings (e.g., schools, primary care clinics), and to consider locating behavioral health services where the populations in need regularly go for services (e.g., senior centers, community centers).

There is also a need to connect more primary care physicians with our behavioral health system. People with substance use disorder and mental health problems have a significant need for physical health services, but often find themselves excluded from getting that care in many offices. It is likely that primary health care providers who accept Medicaid payments will be overwhelmed.

We need to develop more community and peer-based supports, and to integrate those services into the “mainstream” of care. These resources could help address the needs of the people engaged with our systems.

We face challenges regarding electronic health records. There is a problem with poorly integrated databases, which requires duplication of effort; there are problems with small agencies or consumer-run agencies having the capacity to implement or develop IT solutions.

There is the need to have services more integrated across systems. Specifically we need to allow for treatments for both substance use disorder and mental illness, as well as to integrate bi-directionally with primary care without losing necessary specialty services.

Under-served Populations

Mental health and substance use disorder treatment for older adults in Washington state continues to warrant further attention as the unique needs of this population are not always well-understood by policy makers and practitioners, causing older adults to remain a significantly underserved group. The penetration rate for adults and older adults for mental health services is 47 percent and 28 percent, respectively; and for substance use disorder, 32 percent and 11 percent, respectively.

There continues to be a need to address stigma and discrimination against those with behavioral health issues. Mental illness and substance use disorders become evident in a variety of settings where appropriate assistance and support is not readily available. We need to work at early identification and providing resources for support and assistance.

There is often a reluctance to amend or expand data collection to reflect these needs. Some specific population groups cannot be defined geographically, and for these groups there are no consistent data available (e.g., the population of GLBTQ persons, or children of military families, Native Americans) that would contribute to planning of prevention and culturally specific service efforts. Insufficient or inaccurate information on gender identity and on tribal affiliation/membership contribute to a feeling of not being included or respected.

NEEDS ASSESSMENT: DATA-INFORMED DECISION MAKING

The innovative changes in Washington state health care purchasing system driven by state and national legislation are requiring the integration of both mental health and substance use disorder treatment into a behavioral healthcare model and larger integration of behavioral health services into the primary medical service system. These changes have also driven a change in the business model from a fee-for-service to a managed care model and have changed requirements for data collection and reporting. By April 2016, the MHD-CIS and TARGET systems will be replaced with an integrated Behavioral Health Data Store Consolidation (BHDSC) for BHOs and non-tribal providers. TARGET will remain available for the tribal SUD providers, as well as the non-tribal SUD providers who are serving AI/ANs in the SUD FFS system.

By developing an integrated behavioral health data collection, storage and reporting system, the BHDSC project will modernize the flow of data, provide increased security, improve accountability and increase transparency of information, management decisions, and policy development. This effort will also strengthen the management of change, monitoring of service delivery quality and outcome analysis for the entire organization, and further align the organization to a managed care model. In order to establish increased security all changes are integrated into the organization's current IT platforms while allowing all systems and processes to continue without interruption.

DBHR continues to integrate data-informed needs assessment with planning, policy development, service provision, and reporting. The State Epidemiological Outcomes Workgroup (SEOW) plays an important role in primary prevention and treatment planning. Chaired by the DBHR Office Chief for Decision Support and Evaluation and the State Epidemiologist for Non-Infectious Conditions from the Department of Health (DOH), the SEOW is comprised of 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 accurately define the statewide needs by including representatives from the Northwest Portland Area Indian Health Board Epidemiological Center, and the Urban Indian Health Institute as members of the SEOW. During the past year, the SEOW has provided guidance, as well as data support in identifying the state's prevention priorities through the State Prevention Policy Consortium.

As Washington state implements major policy changes such as privatization of spirit sales and legalization of marijuana use, active monitoring of key prevalence indicators and treatment needs is crucial in ensuring that our services are adaptable to the changing environment. In the coming year, the SEOW will continually assess existing data sources, identify data gaps, and develop new data sources. DBHR Quality Improvement Committee, DBHR Management Team, the BHAC, tribes, and stakeholder groups provide input from the criteria presented.

Strategy to Identify Unmet Needs and Gaps

DBHR's planning of prevention and treatment services draws on data from various sources. The biennial statewide **Health 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 five 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, school district, and even school building levels. The most recent administration of HYS in the fall of 2014 provided data for DBHR's needs assessment, including new indicators that expand surveillance capacity for LGBTQ communities and substance use issues related to new marijuana laws.

Tribal schools with a district association are considered a public school and are eligible for HYS if they so desire. Those participating tribal schools are included in the state/county sampling frames. They receive individual school results while their aggregated results are in the higher geographies like their associated district and county (if participation rate requirements for data reporting and aggregation are met).

Independent Tribal Schools, like private schools, can easily register for the survey. They can receive building level results, but their results, while not aggregated, are not included into higher geographies and not included in the state/county samples.

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)** and the **Behavioral Risk Factor Surveillance System (BRFSS)**. The NSDUH estimates and monitors the prevalence rates for different types of substances and BRFSS provides information to identify needs and gaps in various demographic and socioeconomic subpopulations. For example, the Washington BRFSS has questions that allow us to identify pregnant/parenting women and the GLBTQ subpopulation. DBHR has also collected data to assess possible changes in needs in the wake of major policy changes. For example, DBHR added questions in the BRFSS to monitor the use of spirits and medical marijuana in response to recent policy changes. Both NSDUH and BRFSS estimate the prevalence of mental illnesses among adults. With the release of the 2015 data, DBHR will be exploring the use of BRFSS data to provide prevalence rates for Serious Psychological Distress (SPD) at the state and county levels by combining multiple years of data and to explore if it is as a feasible proxy for Serious Mental Illness (SMI).

In the wake of the new state marijuana laws, DBHR worked with researchers at the University of Washington to implement a survey using a convenience sample of young adults to assess changing norms and behaviors. With a greater sample size than that available from the NSDUH and BRFSS, DBHR will be able to detect differences between subpopulations, age groups, and geographic areas. The web-based survey, which included questions about other substance use issues, will inform both prevention and treatment planning.

For specific priority subpopulations, we will draw on data from other state surveys and administrative databases. For example, we will use data from the **Pregnancy Risk Assessment Monitoring System (PRAMS)** to estimate the prevalence of substance use among pregnant women. 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 used develops strategic plans to support the individual, community, and local system level. In addition to HYS, the **Community Outcomes and Risk Evaluation (CORE) System** is 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 and kept at the lowest possible level (at least county level, and address level in some instances). Most indicators originate from the Department of Health, DSHS, the Uniform Crime Report, and the Office of the Superintendent of Public Instruction.

Strategy to Align Behavioral Health Funding with Unmet Needs and Gaps

It is our goal to build resource allocation decision-making on a data-driven process. On-going epidemiological analyses have already informed strategic planning efforts and current funding allocation formulas.

Using a databased approach, the Washington State Prevention Enhancement Policy Consortium developed the state's Substance Abuse Prevention and Mental Health Promotion Five-Year Strategic Plan. The consortium, comprised of representatives from 22 state and tribal agencies and organizations, conducted an extensive review of state-level data on the use/misuse and impact of alcohol, tobacco, marijuana, methamphetamines and prescription drugs, as well as mental health status. The SEOW provided updated data for ongoing monitoring of indicators selected by the SPE to inform any adjustment to the plan.

Prevention funding, under the state's Community Prevention Wellness Initiative (CPWI), goes to the communities with the highest needs. The SEOW identifies highest need communities based on a risk ranking that integrates prevalence and indicators for consequences related to substance use. Using the latest data SEOW periodically update the risk rankings. In 2015, the risk rankings were updated using the 2014 statewide student survey; separate rankings were developed for underage drinking, marijuana use, and all ATOD use. Because the HYS and CORE data are available at the community and school level, many rural and hard-to-reach communities are among those in the current set of 60 CPWI communities.

In preparation for moving towards the integration of mental health and substance use disorder treatment systems, under Behavioral Health Organizations, the funding allocation model for non-Medicaid funded services is being reviewed. In addition to synthetically estimated rates of treatment needs by county, we are evaluating other factors (e.g. utilization patterns, penetration and retention rates) for inclusion in the model. Integrating these factors allows us to maintain focus on priority populations and a full continuum of care.

Mental health resource allocation is 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.

An important aspect of DBHR's surveillance work is the increasingly sophisticated access to data available for providers to help in their own assessment and planning. DBHR has created "the System for Communicating Outcomes, Performance & Evaluation (SCOPE) <http://www.scopewa.net>," a web-based Mental Health and Substance Abuse Performance Indicators. This framework 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. SCOPE is available to treatment providers, regional administrative entities, state program managers, and the public. DBHR's SCOPE reporting system has fulfilled and supported the needs and strategy of former "Uniform Reporting System (URS)" and current "Client-Level Data." It has continued to support the monitoring of service access, quality, and utilization as well as consumer outcomes and to identify gaps and areas for improvement.

There is concern within the tribal behavioral health programs that the mental health Medicaid encounter data does not accurately report the number of tribal Medicaid Tribal clients. Not all tribal members in the behavioral health system are on Medicaid whereby creating a void in the data, which results in an inaccurate representation of need. Most tribal members do not use the BHO services to access mental health services whereby creating an additional void in data.

To address this, DBHR compares synthetic estimates of prevalence to treatment data to understand the unmet need in the Tribes. Synthetic estimates use the Medicaid data as one source to estimate prevalence, but they also incorporate Washington state population survey to capture non-Medicaid people. These estimates of the prevalence of behavioral health need combined with the synthetic estimates of services data provides an indication of the unmet need for treatment.

Having complete data is always a challenge. One of the important things to do when presenting information is to describe accurately the study or reporting population and to be cautious interpreting results. DBHR plans to work with tribes, through the HCA-BHA Monthly Tribal Workgroup, on building strategies of obtaining complete data.

Current Priorities

For substance abuse prevention and mental health promotion, the State Prevention Policy Consortium concluded that underage drinking remains the top priority for prevention for youth and adults. Marijuana ranked second due to high prevalence among youth. Increased attention to capacity building in support of mental health promotion is needed for depression, anxiety, and suicide. In both the analysis of all of these issues among sub-populations and in their own local assessments, tribal programs suggest that heroin is the drug of choice among youth on some reservations. There is also an ongoing problem of opioid abuse and overdose amongst AI/AN youth and adults. Both substance abuse prevention and mental health promotion should focus on youth and young adults, with particular attention given to the needs of the LGBTQ population.

Mental health treatment services continue to focus on the block grant priority population: youth with serious emotional disturbance (SED), and adults and older adults with serious mental illness (SMI). Housing, employment, and education continue to be priority areas for recovery services. We are committed to using evidence-based practices to address these needs.

There are three pieces of state legislation driving the data, reporting, and performance management priorities for DBHR: (1) **Senate Bill 6312**, which directs DSHS to change how it purchases mental health and substance use disorder services; and (2) **House Bill 1519** and **Senate Bill 5732**, which direct DSHS

and the Health Care Authority (HCA) to carry out multiple activities focused on improving the outcomes of adults who receive behavioral health services, including the establishment of accountability measures. To implement this legislation, DBHR has redesigned its data system and aligned its reporting, performance measures, and quality improvement activities to support the system change to an integrated behavioral health managed care model as required by SB6312.

HB1519 and SB5732 mandated state contracting with “service contracting entities” or “service coordination organizations” to include specific performance measures to address outcomes in the following areas:

- Improvement in client health status
- Increases in client in participation in employment, education, and meaningful activities
- Reduced client involvement in criminal justice systems and increased access to treatment for forensic patients
- Reduced avoidable use of hospital, emergency rooms, and crisis services
- Increased housing stability in the community
- Improved client satisfaction with quality of life
- Decreased population level disparities in access to treatment and treatment outcomes

DBHR is committed to improving accountability through implementing continuous improvement processes such as Lean, and performance management vehicles, including the following:

The Department Performance-Based Core Metrics report is a tool to illustrate agency accountability for results. Measures within the report show the agency’s performance in its business and management practices. DBHR includes performance-based metrics in contracts with BHOs and HCA for retention of outpatient substance use disorder treatment, for completion of residential substance use disorder treatment, and for timely transitioning between inpatient and routine outpatient mental health services. Contract managers use performance data in their monitoring activities.

PUBLIC COMMENT ON THE STATE PLAN

Tribes - The Washington State Centennial Accord and Department of Social and Health Services' Administrative Policy 7.01 ensure and maintain a commitment to tribal consultation. Consultation is the formal Government-to-Government meeting to provide an opportunity for an exchange of information and opinion prior to a decision.

In preparation for consultation, roundtables and work groups provide a forum for discussion and problem resolution. When matters are resolved using the round table and work group processes, notification of any outcomes to these meetings are distributed to the affected administration, Office of Indian Policy, tribes, UIHOs, and RAIOS.

For the development of the Block Grant submission, the Division of Behavioral Health Recovery (DBHR) office sent our first letter to the tribal leadership on May 2016, announcing a consultation meeting on July 15, 2016, between the Secretary of DSHS and tribal leaders of the 29 federally recognized tribes in Washington State. The natural conduit for ongoing communications is the HCA-BHA Monthly Tribal Meeting. DBHR is committed to participation in these meetings to further develop and finalize the plan.

Behavioral Health Advisory Council (BHAC) – In accordance with the block grants BHAC is responsible to review the application and progress reports prior to submission. Recommendations are considered for incorporation into the application.

Stakeholders – In July of each year, notices are provided via electronic format to stakeholders, persons with lived experience, the public, and DBHR staff about the opportunity to view and submit written comments on Washington State's block grant plan. Each comment is reviewed and incorporated as appropriate.

WORKFORCE DEVELOPMENT

Prevention

DBHR has a multitude of opportunities in place for communities and prevention providers to build capacity. There are DBHR staff assigned to develop and oversee workforce development in the prevention field and implement a training plan statewide. The training plan is based on a semi-annual survey of the prevention providers to assess needs and interest in training. Monthly one-hour training sessions following an on-line monthly CPWI Learning Community Meeting are part of the training plan. Attendance in the training session is optional, and reaches an average of 75 service providers each month.

DBHR modified the national Substance Abuse Prevention Skills Training (SAPST) is centered on teaching about the Washington State prevention system. The Washington Substance Abuse Prevention Skills Training (WA-SAPST) is held at least twice a year. There is a contractual requirement for all Community Prevention and Wellness Initiative (CPWI) Community Coalition Coordinators to attend the WA-SAPST training within six months of hire.

As of SFY16, CPWI coalition coordinators are required to apply and become certified prevention professionals through the Prevention Certification Board of Washington State (PCBWS). In order to obtain or retain their CPP licensure prevention coordinators can receive additional trainings such as Ethics and evidence-based programs.

DBHR staff developed and delivered a series of webinars that address elements of the Strategic Prevention Framework (SPF). Additionally, webinars have been developed and delivered to address specific training needs of the CPWI Community Coalition Coordinators. A recording of each webinars is posted to the online learning platform associated with The Athena Forum website. Creation of the webinar series is part of the enhancement efforts supported by the Partnerships for Success 2013 grant. Also available on The Athena Forum website are valuable guidance documents and resources related to all aspects of substance abuse prevention and mental health promotion.

DBHR has three major conference trainings. The first is an annual Washington State Prevention Summit that takes place in the fall and attended by both youth and adults. This conference offers information on prevention research and practices as well as a forum for providers to develop new skills for implementing prevention services. The second is the Summer Leadership Institute designed to enhance community coalition development and maintenance skills. The third is a conference specifically designed for youth, the annual Spring Youth Forum, where teams of students make presentations about the projects that they planned during the training they received at the Prevention Summit the previous fall. Prevention providers associated with multiple state agencies participate in all of these conferences. DBHR has also supported “Incredible Years” training and “Mentoring” training specifically for tribal programs.

The Prevention Summit provides education and training to prevent alcohol, tobacco, and other drug use, with an emphasis on preventing underage drinking and prescription drug abuse. Goals include increasing knowledge of prevention science and practice, increasing awareness of state issues, and

promoting the need for continued prevention work by professionals and youth. In 2014, 658 people attended the conference. The 298 youth attendees made up 48 teams and attended leadership workshops for developing and implementing prevention projects in their schools and communities. The majority (92percent) of conference participants would recommend the conference to others. In place of the Annual Prevention Summit for 2015, Washington State, along with two other states, hosted the National Prevention Network (NPN) conference. Youth were encouraged to attend the NPN to create and implement a community project.

The youth present their projects and share their successes at the Spring Youth Forum, which is typically a follow-up conference to the Prevention Summit. However, in FY2015 it was a follow-up to the NPN. This is a peer-to-peer conference for Washington youth teams focused on prevention services where teams can display their work and learn from each other.

The Summer Coalition Leadership Institute is an annual three-day training event to advance the prevention workforce with knowledge and skills. The audience is primarily community coalition coordinators, coalition leadership, Educational Service District partners, and state agency Prevention Policy Consortium Members. Topics this year included understanding academic impacts related to adolescent and young adult substance use. These sessions offered knowledge building to interpret the trend data, ways to develop partnerships, and effective prevention strategies. The participants also received one full day of training on reducing Health Disparities in Washington State. Other sessions included training on basic facilitation skills and group conflict resolution. This training event is an opportunity to highlight other programs having success in the CPWI communities and for the coordinators to network and share successes and challenges to learn from each other. Training is offered at no cost and is written into our Partnerships for Success application and supported with the SABG funding. The Prevention Specialist Certification Board of Washington acknowledged 14 hours for Continuing Education Hours that prevention professionals can use to support their credential.

In addition to formal presentations and training opportunities, the SAPT funds support six Prevention System Managers (PSM) in providing regular and timely technical assistance to the prevention workforce. The PSMs guide CPWI communities and Tribes in development of strategic plans, action plans, and SPF implementation. PSMs work with coalition coordinators to develop plans for communities to maintain compliance with their planned coalition activity. In partnership with Tribes, PSMs work on building plans that incorporate the adaptation of the SPF, innovative programs, and adaptations of evidence-based programs for cultural inclusion and appropriateness. The Healing of the Canoe curriculum is an example of a tribally adapted evidence-based prevention program. The Healing of the Canoe is addresses cultural sense of belonging and cultural revitalization.

The Healing of the Canoe has sought to address issues through a community based, culturally grounded prevention and intervention life skills curriculum for tribal youth that builds on the strengths and resources in the community. Healing of the Canoe has trained 257 attendees from 27 tribes and 10 tribal organizations.

This project has been under development for 11 years and is now in the final phase. Publication for project is available on the ADAI website [The Healing of the Canoe](#).

DBHR supports these three additional statewide conferences each year:

1. Behavioral Health Conference
2. Co-Occurring Disorders and Treatment Conference
3. Saying It Out Loud Conference

The Behavioral Health Conference is a three-day statewide behavioral healthcare conference presented by the Washington Council for Behavioral Health (WCBH) and supported by the Federal Block grant funding administered through DBHR. This year's conference held on June 22-24, 2016, "Strengthening Lives, Building Community" was in Yakima, Washington.

The conference audience includes mental health professionals in areas of aging, corrections, developmental disabilities, children's services, primary health, substance use disorder and other specialties, persons with lived experience and consumer advocates, administrators, staff of public and nonprofit agencies and other stakeholders. This year's funding supported the coordination of registration scholarships for up to 200 persons with lived experience/consumer advocates, and 16 Behavioral Health Advisory Committee (BHAC) members to attend the event.

The Co-Occurring Disorders (COD) and Treatment Conference provides attendees (including consumer and family) with information regarding current legislation related to mental health care/services, current resources, and treatment methodologies. This year the COD Conference had three focus areas including Motivational Interviewing, Trauma, and Medication Assisted Therapies, allowing individuals choosing one of the focus areas to receive nine hours of training on that topic. In addition to the focus areas, there were workshops on marijuana, developmental disabilities, provider self-care, youth, health care reform, and on special populations. The conference also provided opportunities for participants to network with other families and individuals with COD.

The planning for The Saying it Out Loud (SIOL) Conference is done in partnership with the Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) communities, and several divisions or offices within the Department of Social and Health Services (DSHS) (e.g., DBHR, Children's Administration, Division of Vocational Rehabilitation, Development Disabilities Administration, Rehabilitation Administration, and Office of Diversity and Inclusion). This conference brings together professionals from the diverse fields of social work, behavioral health treatment, and human services. It focuses on the impacts of substance use disorder and mental health issues in the LGBTQ communities, as well as current resources and the latest research.

The conference is widely attended by direct service providers, medical professionals, and human services workers etc. who advocate for providing quality care and appropriate services to LGBTQ communities. Since the conference began 15 years ago, interest in attending has been so great that capacity has been increased, accommodating roughly 450 attendees every year.

Each year the keynote speaker and workshop presenters share the latest research and best practices with attendees to increase their knowledge and awareness to promote lifelong health and wellbeing for individuals in LGBTQ communities. Focus topics this year and years past have been related to LGBTQ

youth, and seniors, the transgender community, two-spirit analogy, pre-exposure prophylaxis (PrEP) for HIV infection, intersecting issues such as substance use and mental health disorders and programs with information and answers on how to address these issues.

It is our hope and mission to continue such a relevant and influential conference where professionals can come together to learn, develop relationships and be inspired to provide and promote quality services to individuals and families.

Behavioral Health Organization contracts include a requirement that providers and their staff have opportunities to receive additional trainings in their field of study. Based on the demographics and needs of clients, support trainings are available. See Table 1.

DBHR also works in collaboration with Northwest Addiction Technology Transfer Center (NWATTC) to offer workforce trainings. Trainings offered in Western Washington and Eastern Washington ensure availability statewide. Topic areas include: Introduction to Motivational Interviewing, Clinical Skills in the Era of Legal Cannabis, Behavioral Health Organization (BHO) ASAM training (single training), Co-Occurring Disorders Treatment for Youth, Co-Occurring Treatment for Adults, and Treatment Planning - Measurable, Attainable, Time-Limited, Realistic and Specific, referred to as Treatment Planning (MATRS).

Washington State's Peer Support Program, provided in every region of the state, began training persons with lived experience to become Certified Peer Counselors in 2005. The program will expand to train additional certified peer counselors to meet workforce needs, to provide continuing education of certified peer counselors, and to develop programs to address under-served populations. The program will train providers in utilizing peer workers. In addition to certification training, peer counselor continuing education trainings include Supervision, Ethics, Trauma Informed Care, and Wellness Recovery Action Plan.

Forensic Mental Health Services

The DSHS Office of Forensic Mental Health Services (OFMHS), is responsible for the leadership and management of Washington State's forensic mental health care system, and addresses the increase in demand for mental health services for adults and youth in the criminal justice system. The OFMHS provides forensic evaluations, competency restoration, Not Guilty by Reason of Insanity (NGRI) treatment services, and liaison services to effectively coordinate efforts with system partners to meet shared goals. The OFMHS additionally provides ongoing training and technical assistance to improve quality and timeliness of forensic mental health services; data management and resource allocation; training and certification of evaluators; quality monitoring and reporting. The OFMHS works in collaboration with the Governor's office to lead and implement robust diversion efforts to prevent citizens with mental illness from entering the criminal justice system.

PRIORITY AREAS AND ANNUAL PERFORMANCE INDICATORS

Priority 1:	Reduce Underage and Young Adult Substance Use/Misuse
Goal of the priority area:	Decrease the use and misuse of marijuana, tobacco, Rx drugs, and the use of any other drugs in the last 30 days.
Objectives:	<ul style="list-style-type: none"> • Decrease the percentage of 10th graders who report using alcohol in the last 30 days. (2017 target 19%) • Prevent the increase of 10th graders who report using marijuana in the last 30 days. (2017 target 18%) • Decrease the percentage of 10th graders who report smoking cigarettes in the last 30 days. (2017 target 7%) • Decrease the percentage of 10th graders who report misusing/abusing painkillers in the past 30 days. (2017 target 4%)
Strategies to attain the goal:	<ul style="list-style-type: none"> • Implement performance-based contracting with each prevention contractor. • Adapt programs to address the unique needs of each tribe. • Deliver Evidence-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.
Annual Performance Indicators to measure goal success:	<ul style="list-style-type: none"> • Direct services provided (unduplicated participants). • Count of services delivered (single, recurring, mentoring, and environmental) • Count of programs delivered by CSAP Category. • Percentage of participants receiving evidence-based programs. • Number of trainings provided to build workforce capacity. • Number of technical assistance hours provided to prevention contractors from DBHR.
Baseline measurement:	<p>SFY15 Service Numbers:</p> <ul style="list-style-type: none"> • 15,118 unduplicated direct services provided • 10,996 services delivered (single, recurring, mentoring, and environmental) • 448 Programs by CSAP Strategy <ul style="list-style-type: none"> ○ Alternatives 57 ○ Community-Based Process 76 ○ Education 164 ○ Environmental 35 ○ Information Dissemination 40 ○ Problem Identification and Referral 76 • 87.8% participants received evidence-based programs (12,496) • 13 Learning community webinars, two WA-Substance Abuse Prevention Skills Trainings, the DBHR Summer Institute, and the Washington Prevention Summit were offered to build workforce capacity. • 1,569 hours of technical assistance provided to prevention

	contractors.
First-year target:	<p>Maintain number of prevention programs and participants from SFY15 baseline numbers:</p> <ul style="list-style-type: none"> • 77 Community-wide programs implemented. • 28 Programs focused on addressing favorable attitudes. • 34,219 Individuals reached. • 1,569 Hours of technical assistance provided to CPWI sites. • 48 Youth teams made up of 298 individuals attending the Prevention Summit.
Second-year target/outcome measurement:	<p>Increase service capacity and maintain number of prevention programs delivered to participants receiving services through:</p> <ul style="list-style-type: none"> • Direct services provided (unduplicated participants) • Count of services delivered (single, recurring, mentoring, and environmental) • Programs delivered by CSAP Category • Participants receiving evidence-based programs • Trainings provided to build workforce capacity • Technical assistance hours provided to prevention contractors
Data source:	<p>Washington’s Management Information System (PBPS): used to report the SABG performance indicators.</p> <p>Washington State Healthy Youth Survey (HYS): used to report 30-day use biennially.</p>
Description of data:	<p>SABG performance indicators are used to measure Center for Substance Abuse Prevention Strategies and Institute of Medicine Categories for services provided annually. 10th Grade Substance Use Among Washington Youth is used to measure long-term outcomes.</p>
Data issues/caveats that affect outcomes:	<ul style="list-style-type: none"> • Community Laws and Norms make use favorable 1998 passage of Medical Marijuana, 2012 passage of recreational marijuana, 2011 passage of privatized liquor (I-1183) 2015 passage of the comprehensive marijuana reform act (SB5519) which combines the state regulatory system for medical and recreational marijuana, lack of enforcement of school policies, adult/parental attitudes favorable toward use • Availability The cost is not prohibitive, prevalence of marijuana dispensaries, inability to identify marijuana-infused products, it is easy to get (68% Seattle SD HS students get it from friends, 39% get it from medical marijuana dispensaries). There are more stores selling liquor (I-1183 resulted in an increase from 328 to 1415 stores), it’s easy to get (15% of 10th graders get it from home with approval, 19% give someone money to buy it, 20% take it from home without permission, 31% get it at parties, 37% get it from friends) • Favorable Attitudes Youth think they will not be caught, parents/adults have favorable attitudes toward marijuana use, youth do not perceive harm (decrease of 66% since 2006), peers and adults have favorable attitudes, (28% decrease since 2006 of youth who think it is wrong to use marijuana). Youth who use alcohol think they won’t get caught, parents/adults have favorable attitudes toward alcohol use, youth and adults don’t perceive harm of drinking, peers

	<p>have favorable attitudes toward alcohol use</p> <ul style="list-style-type: none"> • Traumatic Childhood Experiences Family history of substance abuse, divorce, mental illness, domestic violence, physical, sexual or emotional abuse or neglect increase risk • In order to respond to data requests from all funding sources, DBHR will be procuring a new Management Information System to collect SABG indicators in FY17.
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Priority 2:	Increase Youth Outpatient Substance Use Disorder Treatment
Goal of the priority area:	Increase the treatment initiation and engagement rates among youth receiving SUD outpatient treatment. Baseline rates and subsequent targets will be developed in FY2017
Strategies to attain the goal:	<p>Work with BHOs to:</p> <ol style="list-style-type: none"> 1. Determine baseline numbers from good data 2. Develop formula for target percentages 3. Develop target percentage of improvement for each BHO 4. Share data with BHOs on a regular basis for feedback and technical assistance 5. Work toward performance based contracting in 2018 contracts that includes goals, and performance improvement plans with technical assistance for BHOs challenged to keep initiation and engagement rates at or above agreed levels.
Annual Performance Indicators to measure goal success:	<p><u>Initiation of SUD treatment</u> – Percent of youth SUD outpatient and intensive outpatient service episodes^[1] where the client received at least one face-to-face treatment session within the 14 days following the start of a SUD OP/IOP service episode;</p> <p><u>Engagement of SUD treatment</u> – Percent of youth SUD outpatient and intensive outpatient service episodes where the client received at least two face-to-face treatment session within the 30 days following “initiation” of SUD treatment</p>
Baseline measurement:	BHA is currently in the process of launching a new data system to collect client and service information for MH and SUD services provided by Behavioral Health Organizations. Once the quality of data submitted by BHOs is established, BHA will establish a baseline rate for youth SUD treatment initiation and engagement. The baseline will be based on the 6-12 month period following the date where the quality of data submitted by BHOs reached an acceptable level.
First-year target:	Due to the implementation of a new data system (see above), baseline will be developed during the first year. Targets for the second year will be identified after baselines have been established.

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Second-year target/outcome measurement:	Convene internal workgroup to establish second year targets once baselines are established.
Data source:	Behavioral Health Data Store
Description of data:	Initiation and engagement rates are based on SUD encounters submitted to Provider One by BHOs and service episode start dates submitted directly to BHA by BHOs through "native transactions".
Data issues/caveats that affect outcomes:	As previously mentioned, BHA is in the process of launching a new data system. In addition to expected issues with data quality in the early stages, other unanticipated issues may emerge. BHA is implementing processes to identify issues quickly and will work with BHO's to resolve identified issues in a timely manner.

Priority 3:	Increase outpatient mental health services for adults
Goal of the priority area:	Increase number of adults (18 and over) receiving outpatient mental health services from 56,000 to 62,000
Strategies to attain the goal:	<ul style="list-style-type: none"> • Convene Medicaid enrollment workgroup to determine best practices for enrollment at point of first contact. • Gather data and resources regarding how potential persons with lived experience are identified and located through Geo-mapping and other available data systems. • Convene Service Engagement Workgroup to address engagement in treatment at intake
Annual Performance Indicators to measure goal success:	
Baseline measurement:	RSN service data third quarter FY 2013
First-year target:	<ul style="list-style-type: none"> • Assemble population analysis to inform Medicaid Enrollment Workgroup. Convene Medicaid Enrollment Workgroup to determine best practices • Gather data to show impact of in-person supports/potential data for funding requests for ongoing in-person supports (in-person assisters) • Convene Service Engagement Workgroup to address engagement in treatment at intake
Second-year target/outcome measurement:	<ul style="list-style-type: none"> • Improve access in underserved areas. Improve engagement at intake
Data source:	Behavioral Health Data Store
Description of data:	The number of adults (18 and over) receiving outpatient mental health services
Data issues/caveats that affect outcomes:	<ul style="list-style-type: none"> • Lack of in-person supports to help persons with lived experience. • Lack of consumer enrollment in Medicaid at first contact. Intake process not customer focused • Geographical access issues • Lack of marketing and education about services

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	<ul style="list-style-type: none"> • Slow and often unsuccessful transitions across system
Priority 4:	
Goal of the priority area:	Increase outpatient substance use disorder treatment for adults
Objective:	Increase percentage of outpatient substance use disorder treatment retention in adults from 68.7% to 70.7%.
Strategies to attain the goal:	<p>Work with BHOs to: Determine baseline numbers from good data</p> <ul style="list-style-type: none"> • BHA is currently in the process of launching and new data system to collect client and service information for MH and SUD services provided by Behavioral Health Organizations. • Once the quality of data submitted by BHOs has been established, BHA will establish a baseline rate for adult SUD treatment initiation and engagement. The baseline is for a 6-month period following the date where the quality of data submitted by BHOs reached an acceptable level.
Annual Performance Indicators to measure goal success:	<p><u>Initiation of SUD treatment</u> – Percent of adult SUD outpatient and intensive outpatient service episodes^[1] where the client received at least one face-to-face treatment session within the 14 days following the start of a SUD OP/IOP service episode;</p> <p><u>Engagement of SUD treatment</u> – Percent of adult SUD outpatient and intensive outpatient service episodes where the client received at least two face-to-face treatment session within the 30 days following “initiation” of SUD treatment</p>
Baseline measurement:	BHA is currently in the process of launching a new data system to collect client and service information for MH and SUD services provided by Behavioral Health Organizations. Once the quality of data is submitted by BHOs, BHA will establish a baseline rate for adult SUD treatment initiation and engagement. The baseline is for the 6-month period following the date where the quality of data submitted by BHOs reached an acceptable level.
First-year target:	Due to the implementation of a new data system (see above), baseline will be developed during the first year. Targets for the second year will be identified after baselines have been established.
Second-year target/outcome measurement	Convene internal workgroup to establish second year targets.
Data source:	Behavioral Health Data Store
Description of Data:	Initiation and engagement rates are based on SUD encounters submitted to Provider One by BHOs and service episode start dates submitted directly to BHA by BHOs through “native transactions”.
Data Issues/Caveats that affect Outcomes:	As previously mentioned, BHA is in the process of launching a new data system. In addition to expected issues with data quality in the early

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	stages, other unanticipated issues may emerge. BHA is implementing processes to identify issues quickly and will work with BHO's to resolve identified issues in a timely manner.
Priority 5:	
Goal of the priority area:	Decrease homelessness for individuals served by the behavioral health system
Objective:	Increase housing stability and decrease homelessness by serving 1000 individuals with supportive housing services through pilot projects over a two-year period. Increase awareness of the impact of homelessness on health and behavioral health through training and technical assistance.
Strategies to attain the goal:	<ul style="list-style-type: none"> • Washington will build upon the chronic homeless policy academy and strategic planning processes as well as national technical assistance received through SAMHSA and HUD to facilitate and develop stronger relationships and agreements with state and local housing, community development agencies and HUD over the next year. • Pilot projects and grant-funded projects in Washington State have demonstrated the need for, as well as, the success of supportive housing services. Replication and dissemination of the service model would continue through the implementation of four new Housing and Recovery through Peer Services (HARPS) teams. • Data collection and outcome evaluation as well as facilitating stronger relationships with proprietors of affordable housing stock and community room and board resources implemented through policy academy workgroups, webinars and conference presentations.
Annual Performance Indicators to measure goal success:	<ul style="list-style-type: none"> • Conduct an evaluation on supportive housing projects such as Housing & Recovery through Peer Services (HARPS). • Conduct training on SAMHSA's Evidence-base Practice Permanent Supportive Housing model through webinars, conferences and technical assistance. Report on numbers trained.
Baseline measurement:	Between July 2014 and March 2016 approximately 300 individuals received supportive housing services through 3 pilot projects entitled Housing and Recovery through Peer Services (HARPS)
First-year target:	<ul style="list-style-type: none"> • Establish four new HARPS teams, provide supportive housing services and housing bridge subsidies and serve 500 individuals served through pilot projects. • Increase awareness and fidelity to EBP PSH model through training and technical assistance to 500 individuals through webinars, conferences presentations and workshops,
Second-year target/outcome measurement:	<ul style="list-style-type: none"> • Maintain seven HARPS teams; provide supportive housing services and housing bridge subsidies. Serve an additional 500 individuals through pilot projects (services and/or bridge subsidies) • Increase awareness and fidelity to EBP PSH model through training and technical assistance to 600 individuals (clinicians, peers, etc.) through webinars, conferences presentations and workshops,
Data Source:	Behavioral health data systems
Description of data:	Service encounters, program enrollment numbers and reports with subsidy expenditures

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Data issues/caveats that affect outcomes:	
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Priority 6:	Increase outpatient mental health services for youth
Goal of the priority area:	Increase the number of youth receiving outpatient mental health services
Strategies to attain the goal:	Increase the use of wraparound community based mental health services and supports Enhance transition planning to reduce inpatient utilization
Annual Performance Indicators to measure goal success:	The number of youth receiving outpatient mental health services will increase each quarter while maintaining or decreasing inpatient utilization
Baseline measurement:	Third quarter FY13 average of 23,000
First-year target:	Increase from the third quarter average of 23,000 to 27,000
Second-year target/outcome measurement:	Increase monthly caseload capacity of youth receiving wraparound in home and community settings from 800 to 1600
Data source:	Mental Health Consumer Information System (CIS), via the System for Communicating Outcomes, Performance and Evaluation (SCOPE-WA)
Description of data:	Number of Medicaid and Non-Medicaid youth (under age 18) receiving (1) outpatient mental health services and (2) inpatient (i.e., Community Hospital Psychiatric Unit services or Evaluation and Treatment [E&T] Center) services from BHOs; and (3) inpatient services from the Child Study and Treatment Center (CSTC) and the Children's Long-Term Inpatient Program (CLIP).
Data issues/caveats that affect outcomes:	Wraparound services not yet available statewide and lack of uniformity on acute care policy and utilization

Priority 7:	
Goal of the priority area:	Increase employment and earning for individuals with behavioral health issues
Objective:	Increase employment for 150 individuals receiving BHA-funded behavioral health services. Increase awareness of the impact of long-term unemployment on health and behavioral health through training and technical assistance.
Strategies to attain the goal:	Evidence of the beneficial effects of evidence based supported employment coupled with the clearly delineated deleterious effects of long-term unemployment offers strong fiscal and therapeutic rationales for a targeted supported employment services. Washington was chosen for a 2014 SAMHSA sponsored Olmstead policy academy to improve employment outcomes for individuals with behavioral health disabilities as well as the Dartmouth Psychiatric Research Center's Supported Employment Learning Collaborative. A strategic plan developed with 3 areas of focus: Identifying funding for supported employment services; educate the behavioral health workforce on the negative impact of long-term unemployment and educate the community including individuals;

	<p>family members and employers on the benefit of employment for people with behavioral health issues.</p> <ul style="list-style-type: none"> • Supported employment pilot projects and grant-funded projects are currently underway in Washington State and will assist in scaling and replicating supported employment services. Fidelity review processes will be established utilizing national learning collaborative models through the Dartmouth Psychiatric Research Center. • Stakeholder education and training: Through a federally funded SAMHSA grant, training on evidence-based practice Supported Employment (also known as the Individual Placement and Support model) will be provided to BHOs and provider agencies. Workforce education on the negative impact of long-term unemployment on individual’s mental and physical health will be provided through federal grant resources including to BHO personnel, and the provider community. Stakeholder education and anti-stigma campaigns for employers will be held. • Client Outreach and education: Inclusion of the benefits of employment will be included in the Pathways to Employment website, benefit booklets, postcards or other marketing devices as well as webinars to publicize the supportive employment service availability. Information will also include dissemination of the Washington Medicaid Buy-In program called Healthcare for Workers with Disabilities that has demonstrated achieving greater self-sufficiency while obtaining comprehensive health care and benefits needed by workers with disabilities. • Implement Social Security’s Ticket to Work program on behalf of provider organizations and consumers through DBHR’s status as an Administrative Employment Network.
Annual Performance Indicators to measure goal success:	<ul style="list-style-type: none"> • Conduct an evaluation on the Temporary Aid to Needy Families (TANF) Supported Employment Pilot Project. • Conduct training on SAMHSA’s Evidence-base Practice Supported Employment model through webinars, conferences and technical assistance. Report on Numbers trained.
Baseline measurement:	<p>From April 2015 through December 2015, approximately 100 participants received supported employment services through the TANF SE pilot project.</p>
First-year target:	<ul style="list-style-type: none"> • Increased awareness and fidelity to EBP SE model through training and technical assistance to 500 individuals • 200 individuals served through pilot projects such as the TANF SE pilot and the SAMHSA funded Becoming Employed Starts Today grant funded project. • 10 Tickets assigned to DBHR through the Ticket to Work program
Second-year target/outcome measurement:	<ul style="list-style-type: none"> • Increase awareness and fidelity of EBP SE models through training and technical assistance to 500 individuals through webinars, conference presentations and workshops. • 100 additional individuals served through supported employment pilot projects

	<ul style="list-style-type: none"> 25 Tickets assigned to DBHR through the Ticket to Work program
Data source:	Behavioral Health data system, SSA Ticket to Work Portal
Description of data:	CIS data and Provider One Service encounter data.
Data issues/caveats that affect outcomes:	CIS data crossed with employer-reported earnings and hours data collected by the Washington State Employment Security Department on quarterly basis is delayed by 6-9 months.

Priority 8:	Drug Court-Enhancement of Drug Court through implementation of National Association of Drug Court Professionals (NADCP) Best Practices
Goal of the priority area:	Implementation of NADCP Best Practices within the Drug Courts in the state.
Objectives:	All Drug Courts will be required to begin implementing best practices.
Strategies to attain the goal:	<p>Ensure all Drug Courts are implementing best practice within their Drug Courts by:</p> <ul style="list-style-type: none"> training at WSADCP conference individual training through a collaboration of DBHR and AOC to webinars for specific roles within the court Coordinator conference to provide the opportunity to train the coordinators.
Annual Performance Indicators to measure goal success:	Ensure all Drug Courts are implementing best practices through peer review. Site visits DBHR and Association of Courts (AOC) collaboration. Peer Review reports annually.
Baseline measurement:	<ul style="list-style-type: none"> Number of Best Practices implemented within the Drug Court based on peer review. Reduction in Recidivism Rate, dropout rate, positive UA rate, revocation rate for the Drug Court. Increase in Employment, School, Stable Housing and Co-occurring treatment for the Drug Court.
First-year target:	<ul style="list-style-type: none"> Three of 7 of the Best Practices implemented. Five percent reduction in recidivism rate, dropout rate, positive UA rate, revocation rate for the Drug Court from the baseline. Five percent increase in Employment, School, Stable Housing and Co-occurring treatment for the Drug Court from baseline.
Second-year target/Outcome measurement:	<ul style="list-style-type: none"> Seven of seven of the Best Practices implemented. Ten percent reduction in recidivism rate, dropout rate, positive UA rate, revocation rate for the Drug Court from the baseline. Ten percent increase in employment, school, stable

	housing and co-occurring treatment for the Drug Court from baseline.
Data Source:	RDA Drug Court Dashboard
Description of data:	RDA has access to all state services citizens use; they plan to compile that documentation into one resource for Drug Courts within the state.
Data issues/caveats that affect outcomes:	<ul style="list-style-type: none"> • The dashboard is not yet completed. • Geographical access to resources.

HEALTH DISPARITIES

State Tracking on Access or Enrollment in Services

Individual level services' reporting allows us to track access to services and to identify subpopulations or geographic areas that are unserved or underserved by our current system. Specific outpatient, residential, and inpatient services are collected and reported by race, ethnicity, gender, LGBT, and age. This reporting also provides data to monitor vendor performance and track treatment outcomes. The **Treatment and Assessment Report Generation Tool (TARGET)** is DBHR's web-based management and reporting system for substance use disorder client services that provide information on services provided by substance use disorder agencies throughout the state. The **Consumer Information System (CIS)** collects and reports on mental health services provided by Regional Support Networks (RSNs) and their subcontractors as well as services provided at community and state hospitals. The **Provider One** system contains medical billing and encounter data for Medicaid clients and it is one of the source systems that feed the **CIS**. We use these data systems to evaluate utilization patterns, penetration rates, treatment profiles, and provider performance. The **Integrated Client Databases (ICDB)**, which contains longitudinal client service histories and outcomes, will support our analyses of client interactions with other DSHS services. All these factors will inform DBHR's resource allocations.

Addressing the Needs of Racial, Ethnic and Sexual Minorities

DBHR has worked to develop a strong relationship with Washington's 29 federally recognized tribes and three non-federally recognized tribes to improve the behavioral health of tribal members. In accordance with the Department's Administrative Policy 7.01, DBHR must submit an Annual State Plan that addresses issues common among tribes and Urban Indian Programs. Meetings between DBHR staff and tribal governments provide a forum to discuss Government-to-Government protocol, policy impacts, contracting issues and funding opportunities. The meetings also provide an opportunity to share information and discuss current issues.

Currently, Washington Administrative Code requires mental health services to be provided by or in consultation with a person who qualifies as a mental health specialist in the applicable consumer service group, including African Americans, Hispanic, Asian/Pacific Islander, Native American, older adults, children, and developmentally disabled consumers. Specialists need either to sign off on or be involved in treatment planning. The intent of this regulation is to provide culturally competent care.

The contracts with counties and providers all services be designed and delivered in a manner sensitive to the needs of ethnic minorities and/or the youth/family/consumer and their community. Per contractual agreement, providers are to initiate actions to ensure or improve access, retention and cultural relevance of treatment, prevention or other services. Contractors are required to take the initiative to strengthen working relationships with other agencies that provide services to underserved or particularly vulnerable populations. Contractors and providers are to report annually the actions taken with the identified populations and the building of relationships with other agencies.

Linguistic Disparities/Language Barriers

DBHR has provide culturally appropriate public relations materials outlining services to culturally diverse communities, including materials in alternative formats and translated in languages reflected in

Washington state communities. Moreover, DBHR advocates for funding to ensure that behavioral health treatment and prevention program budgets address the goal of ensuring linguistically appropriate forms, surveys, and information for its diverse stakeholder groups and coalitions (spoken language and deaf and hard of hearing).

Language Assistance Services

DBHR continues to ensure that its service recipients have equal access to print and electronic publications in their native and most fluently spoken languages and to facilitate interpretation services for those served in both licensed and certified behavioral health facilities.

Cultural and Linguistic Competency Training

DBHR has been using Block Grant funding to provide trainings to meet the educational requirements for credentialing individuals as mental health specialists. In addition, trainings are available for credentialing of developmental disability specialists, Native American specialists, and child specialists. The SAPT Block Grant has funded cultural competency trainings for chemical dependency professionals, and DBHR staff are required to attend tribal relations training. DBHR understands that cultural competency must also include specialist services for children, older adults, gay/ lesbian/ bisexual/ transgender/ questioning (GLBTQ) populations, persons with disabilities and veterans. We are committed to focusing on the recruitment of a more diverse workforce and the development of sustainable mechanisms for cultural competency training.

The contracts with BHOs for substance use disorder services require that all services be designed and delivered in a manner sensitive to the needs of ethnic minorities and/or the youth/family/consumer and their community and AI/ANs pursuant to the federal trust responsibility. BHOs are to initiate actions to ensure or improve access, retention, and cultural relevance of treatment, prevention, or other services. BHOs are required to take the initiative to strengthen working relationships with other agencies that provide services to underserved or particularly vulnerable populations. BHOs report annually about the actions taken with the identified populations and the building of relationships with other agencies.

EVIDENCE-BASED PRACTICES FOR EARLY INTERVENTION FOR PSYCHOSIS (10%)

The MHBG 10% Set Aside will support the startup of two Coordinated Specialty Care (CSC) teams, and continue to fund the current New Journeys Demonstration Project at Central Washington Comprehensive Mental Health in Yakima, which began in March 2015. These three Demonstration Projects will form the beginning of the New Journeys Network in Washington State. All Demonstration Project sites will 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 will be the Project Director and will oversee all aspects of implementation, including program start up, training, ongoing consultation, and coordination and planning between the Demonstration Projects and DBHR. Dr. Monroe-DeVita will be joined by her training team at UW, along with national experts from the NAVIGATE program and EASA Center for Excellence at Portland State University.

New Journeys places a strong emphasis on outreach and engagement.¹ There will be dedicated staff time to these activities with a central point of referral and coordinated entry to the program. Staff will develop referral pathways, cultivate relationships, and provide community outreach. They will be responsible for client and family engagement, which includes assertive outreach, rapid contact after referral, efficient enrollment, and ongoing education and support. Staff will: use “hopeful” messages with an emphasis on the individuals’ goals, describe how their experience with symptoms have affected their daily life, and how services will be helpful to the individual. Admission interviews to eligible individuals are timely and referrals to more appropriate services are offered to ineligible individuals.

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

Beyond the efforts outlined above, we know that key partnerships are necessary to ensure Washington State’s Early Psychosis Identification and Intervention efforts are embedded in systems change as new strategies and behavioral health care policies are being developed across the state.

In addition to the resources and activities outlined above, DBHR is a partner with Washington State’s Research and Data Analysis’ (RDA) team and the University of Washington (UW) School of Medicine, Department of Psychology and Behavioral Sciences to focus specifically on outcomes and data measures.

¹ Community Outreach and Prevention as an Element of Early Intervention in Psychosis
<http://www.thenationalcouncil.org/events-and-training/webinars/webinar-archive/>

The overarching goals of the RDA and UW evaluation and research project are to examine the effectiveness of the early psychosis model being developing in Washington State, as well as conceptualizing the needs and adaptations that will allow sustainable implementation at rural, suburban, and urban sites.

The research and evaluation project will be collaborative, recovery oriented and client centered. The goal will be to engage TAY with SMI or SED, families of the TAY, and providers to examine issues that matter to them, such as the duration and quality of life, functional outcomes, and costs of care. Beyond looking at treatment itself, there will be measures of the impact and value of the New Journeys model, as well as the impact of social factors on therapeutic outcomes.

PROGRAM INTEGRITY

DBHR works with 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 and Tribes in their efforts to combat fraud and abuse and promote best practices to enhance awareness of fraud, waste, and abuse.

Contract requirements are passed down to contractors and their subcontractors. Generally, a review is once per year or once per biennial contract. Additional reviews and audits are frequently when there is high-risk concerns. Monitoring the appropriate use of block grant funds and oversight practices include:

- Budget review - leadership reviews the block grant budget allocations monthly
- Claims/payment adjudication - Audit requirements for the county and providers
- Expenditure report analysis - Expenditure reports are reviewed as part of monthly invoice payment process
- Compliance reviews through an A-19 billing document, TARGET review, on-site visits
- Client level encounter/use/performance analysis data

Outpatient services, provided by a BHO subcontractor, receive funding through the BHO contracting process. BHOs will be entering all the services billed for block grant funding in their individual data systems, and then send the required data to DBHR to review the data and confirm the services and expenditures. Tribal programs receive reimbursement using a fee-for-service model. Tribal programs who receive block grant funding through the Intergovernmental Agreement with the Department of Social and Health Services for Contract Consolidation enter their data into the TARGET system, where DBHR can view the data and confirm the services and expenditures.

For residential treatment, the payment structure is negotiated between the BHOs and their subcontracted providers. The FFS system handles payment in two ways: if the FFS provider is a non-institution for mental disease (IMD) facility, then services under the FFS program can be billed directly to the Provider One system. If the FFS provider is an IMD facility, the provider can bill services directly to DBHR on an A-19 form.

The responsibility of on-site monitoring has moved to the BHOs, with the exception of prevention and tribal Contract Consolidation programs. All programs that receive block grant funding receive an on-site monitoring visit no less than once per biennium. If there is an issue related to utilization or services, a corrective action plan is initiated and monitoring visits occur more frequently.

TRIBES

The Division of Behavioral Health and Recovery is committed to the establishment of inter-governmental relationships with the tribes of Washington State and to the development and delivery of beneficial services to Indian families and individuals in need. DBHR recognizes the importance of collaborating with tribes, Urban Indian Health Organizations (UIHOs), and Recognized American Indian Organizations (RAIOs) across the state to assure that Indian people have access to services that are culturally sensitive and appropriate.

Tribal representation is integral to ensuring that DBHR is able to meet the needs within tribal communities. The department's Office of Indian Policy (OIP) and IPAC assist DBHR in reaching out to tribal members to participate on each advisory council. IPAC is an advisory committee, within DSHS, with representatives from the 29 federally recognized tribes and seven Recognized American Indian Organizations (RAIOs) within Washington State.

Washington State's Department of Social and Health Services (DSHS) established a consultation policy, called Administrative Policy 7.01, in collaboration with the Indian Policy Advisory Committee (IPAC). Administrative Policy 7.01 gives the protocol for communication and collaboration with the federally recognized Tribes, UIHOs, and RAIOs in Washington State, as well as the protocol for consultation with the federally recognized tribes in Washington State.

In 2013, the Tribal Centric Behavioral Health Workgroup submitted a report to the Legislature describing a Tribal Centric Behavioral Health System and identifying the steps necessary to implement the system. The report is required by Section 7 of Substitute Senate Bill 5732. In the report, the workgroup identified the defining characteristics that exemplify a Tribal Centric Behavioral Health System. Those characteristics should demonstrate:

- The value and importance of individual choice.
- The value and importance of an AI/AN individual having access to tribal and urban Indian programs providing behavioral health services.
- Mandatory changes to BHOs and their relationship with tribes and AI/individuals.
- Required cultural competency training for BHO and state hospital staff working with the AI/AN population.
- Coordinated and centralized communications between DSHS and Health Care Authority in policy development and designing, and modifying billing and reporting procedures.
- Conducting a feasibility study for structuring one or more residential programs. The study should determine what type of facility would best serve the AI/AN population (freestanding evaluation and treatment (E&T), crisis triage, dual diagnosis beds, or a combination of all three).

The Tribal Centric Behavioral Health initiative works across all aspects of BHA. The DSHS Office of Indian Policy is one of its primary partners. The initiative's work actively involves representatives from the American Indian Health Commission, the Indian Policy Advisory Committee, the Northwest Portland Area Indian Health Board, Health Care Authority (HCA), and Indian Health Services (IHS).

Historically, the workgroup helped shape and design a new mental health system for AI/ANs. The workgroup's recent focus (between the years 2013-2016) was on the implementation of Substitute Senate Bill 6312, which integrated publicly funded SUD treatment programs into the public mental health system, transitioning SUD treatment into a managed care environment, through new entities called Behavioral Health Organizations (BHOs) which were implemented April 1, 2016. However, following consultation with the Tribes it was decided to carve out the Medicaid-eligible AI/AN population from the BHO SUD services. Tribal providers continue to directly refer their Medicaid-eligible AI/AN clients to substance use disorder outpatient and inpatient providers within the FFS system.

HCA and BHA have combined their monthly tribal meetings to increase centralized communication between the two agencies to our tribal partners; this transformed the Tribal Centric Behavioral Health Workgroup to the HCA-BHA Monthly Tribal Meeting. Through the work of all the representatives mentioned above, the two agencies have formed an issues grid that lists the concerns that must be addressed to better serve AI/ANs within the Washington State Behavioral Health System. The two agencies have agreed to make this issues grid a standing agenda item at each monthly meeting, as well as continue to pursue the implementation of other recommendations within the 2013 Tribal Centric Report to the Legislature.

PRIMARY PREVENTION FOR SUBSTANCE ABUSE

State Epidemiological Outcomes Workgroup (SEOW)

Washington State has an active SEOW, which meets quarterly. The SEOW, first established in January 2005 as part of the Strategic Prevention Framework State Incentive Grant (SPF SIG), has been active since then. DBHR staff currently support it, with core members from DSHS (Division of Behavioral Health and Recovery and the Division of Research and Data Analysis), the Department of Health, Washington State Institute for Public Policy, and the University of Washington.

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 reduce substance use and promote mental health. These measures provide information on the full spectrum of indicators including risk and protective factors, and long-term health and social consequences of substance misuse or mental illness.

SEOW uses data from both national and state surveys, as well as administrative databases. Data are collected statewide covering all age and demographic groups. To allow for more in-depth geographic analysis, data is maintained at the lowest geographic level possible. This approach allows us to use data to support community-based initiatives.

The SEOW collects and provides guidance on the collection of various types of data related to substance misuse and mental health, including consumption/prevalence, consequence, and intervening variables.

<p>BRFSS</p> <ul style="list-style-type: none"> • Core questionnaire • State-added questions 	<p>Consumption:</p> <ul style="list-style-type: none"> • Alcohol: alcohol consumption module, use of liquor • Marijuana: current, lifetime use; mode of use, medical marijuana use • Prescription drugs: use of pain killers <p>Consequence:</p> <ul style="list-style-type: none"> • Drinking and driving; driving under the influence of marijuana 	<ul style="list-style-type: none"> • Adults 18 and above; • All race/ethnicity groups.
<p>NSDUH state estimates</p>	<p>Consumption:</p> <ul style="list-style-type: none"> • Alcohol, tobacco, marijuana, prescription pain relievers, illicit drugs <p>Consequence:</p> <ul style="list-style-type: none"> • Dependence or misuse <p>Intermediate:</p> <ul style="list-style-type: none"> • Perception of risk in binge drinking, smoking marijuana and cigarettes 	<ul style="list-style-type: none"> • Youth, young adults, and adults

<p>WA Young Adult Health Survey</p> <ul style="list-style-type: none"> • State-developed internet-based survey • Annually 2014, 2015 	<p>Consumption:</p> <ul style="list-style-type: none"> • Extensive set of questions on marijuana use rates and use patterns • Rates and use patterns of alcohol, tobacco, heroin and pain relievers <p>Consequence:</p> <ul style="list-style-type: none"> • Physical and mental problems caused by marijuana and alcohol use • Driving under the influence of marijuana <p>Intermediate:</p> <ul style="list-style-type: none"> • Perception of access, risk, and norms about the use of marijuana, alcohol, heroin, and pain relievers 	<ul style="list-style-type: none"> • Young adults 18-25 • All race/ethnicity groups • Urban and rural areas
<p>The Community Outcomes and Risk Evaluation (CORE) System</p> <ul style="list-style-type: none"> • Archival indicator database and reports • Updated twice a year 	<p>Consequence:</p> <ul style="list-style-type: none"> • Alcohol and drug related deaths • Criminal justice involvement • School attendance and academic outcomes • Alcohol-related traffic fatalities • Clients of alcohol and drug treatment services <p>Intermediate</p> <ul style="list-style-type: none"> • An extensive set of variables in community, school, family, and individual domains 	<ul style="list-style-type: none"> • Youth, adults, family, community, schools • Reported at the state, county, locale, and school district levels

Strategic Planning

The state has a current Substance Abuse and Mental Health Promotion Five-Year Strategic Plan that was developed in 2012 and updated in November 2015 with the 2014 Healthy Youth Survey and Core GIS data and resources assessment. The current plan is available in the following link.

<http://www.theathenaforum.org/sites/default/files/SPE%20Strategic%20Plan%202015%20Update%20FINAL%20for%20Athena.pdf>

The plan informs decisions about the use of primary prevention set-aside. The prioritized outcomes, identified in the Substance Abuse and Mental Health Promotion Five-Year Strategic Plan, relate to youth alcohol use, marijuana misuse and abuse, and prescription medicine misuse/abuse are encouraged as priorities for our CPWI communities to address. Any special project or capacity building needs are informed by the Substance Abuse and Mental Health Promotion Five-Year Strategic Plan.

Data Collection and Outcomes

The state uses this data in their Substance Abuse and Mental Health Promotion Five-Year Strategic Planning process and for developing state goals and outcome benchmarks related to underage youth alcohol use and youth marijuana misuse and abuse.

The state prioritizes funds in the Community Prevention and Wellness Initiative to reach high-need communities. Highest need communities are based on a Risk Profile prepared by the State Epidemiological Outcomes Workgroup (SEOW) and provided to the counties and Educational Service

Districts (ESDs) for the local community selection process. The Risk Profile includes rank listings of highest need communities based on the following indicators: consumption (alcohol), consequence (school performance, youth delinquency and mental health), economic deprivation, and troubled family.

Once a high-need community is selected by the County and ESD, DBHR supplies data to each CPWI community in the form of a Data Book, or data report, to be used in the initial assessment phase of the Strategic Prevention Framework and at update intervals. This is the planning framework for the Community Prevention and Wellness Initiative (CPWI). Databased decision-making drives this framework. The needs assessment helps communities identify where they need to focus prevention efforts and programming.

The Data Books are annually provided with the new data from each biennial Student Survey administration (known as the Healthy Youth Survey). Production of the Data Books is a project of the Epidemiological Outcomes Workgroup, and produced with the assistance of RDA.

The Data Books include measures for the Consequences, Consumption, and Intervening Variables in the CPWI logic model; the measures appear in the same order as in the logic model. The intervening variables are those most strongly associated with alcohol use, such as availability of alcohol, enforcement of alcohol laws, community norms regarding alcohol use/misuse, and five Risk and Protective Factor Scale Scores. The information comes from student responses to HYS and from CORE; the measures selected are because they have the strongest predictive value for alcohol use/misuse.

The Data Books also show these and other data across several years to demonstrate long-term changes in the communities. The measures also appear in the same order as in the CPWI logic model. The Data Books contain the following:

The Community Outcomes and Risk Evaluation Information System (CORE)

The CORE contains archival indicators (or social indicators) that are highly correlated with adolescent substance use, and the risk factors that predict substance use. There are currently 47 indicators, most of which originate from the Department of Health, Department of Social and Health Services, Uniform Crime Report, and the Office of the Superintendent of Public Instruction. Twice a year, data is published on a public website and reported at the lowest feasible geography level: state, county, school district/community, and locale (a geography that incorporates more than one school district when the base population of the school district is too low for reliable reporting). See: <https://www.dshs.wa.gov/sesa/research-and-data-analysis/community-risk-profiles>.

Washington State Healthy Youth Survey (HYS)

The Healthy Youth Survey is a bi-annual adolescent health behavior survey administered in school classrooms of 6th, 8th, 10th and 12th graders and, for the first time in 2014, 7th, 9th, and 11th grade classrooms in small school districts that elected to participate in the Small School Pilot. In 2012 and 2014, more than 80 percent of Washington school districts participated in the survey sponsored by five state agencies. The questions cover a wide variety of health and school success behaviors, from diet and nutrition to binge drinking to school skipping. State and county reports are available to the public at

www.AskHYS.net. School district reports are password protected. Data sharing agreements for analyses are available through the Department of Health.

Two types of Tribal Schools participated in the HYS – those with a district association and those that are independent. Tribal schools with a district association eligible for the HYS like any other public school. They are included in the state/county sampling frames. They receive individual school results and are aggregated up into higher geographies like their associated district and county. (If they meet participation requirements).

Tribal Schools w/District Association include:

- Chief Leschi Schools, associated with Puyallup
- Paschal Sherman, associated with Omak SD
- Quileute Tribal School, associated with Quillayute Valley SD
- Wa He Lut Indian School, associated with North Thurston SD
- Yakama National Tribal Jr./Sr. High School, associated with Wellpinit SD

Independent Tribal Schools are like private schools. They can participate in HYS like any private school. We did add them all to the list of schools on the registration form so they can easily register for the survey. Because they are not “public” recruitment letters, reminder emails, or other recruitment efforts are not sent to them. They can receive building level results, but their results are not aggregated into higher geographies and they are not included in the state/county samples.

Independent Tribal Schools include:

- Chief Kitsap Academy
- Lummi Nation School
- Muckleshoot Tribal School

The goal of the assessment phase of the CPWI planning process is to guide the coalition as they select priorities for prevention work. Those priorities, based on the risk factors, are most closely linked to the substance use in their communities and the resources they for addressing those risk factors. This report includes data for the needs assessment part of that phase of the process. The data come from the Healthy Youth Survey, and from the CORE Information System (CORE), which is a collection of archival data from many different sources.

Community Readiness

Using the ranked risk profiles, counties follow a selection process that would identify communities that were at a high enough level of readiness to benefit from services, while being underserved and at a high-need for services. Community support assesses readiness for developing and implementing the CPWI. This was determined by documenting support from at least eight of the twelve required community representative sectors that serve or live in the defined community and agree to join the coalition. Additionally, school district support is assessed and documented to house and leverage

funding to support the required match costs for the prevention/ intervention specialist in the middle and or high school in the community.

Allocation Formulas

DBHR prioritizes funding for scientifically proven strategies to prevent substance use, 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 client service contracts
- Community-based organization contracts
- Interlocal contracts
- Consolidated Intergovernmental Agreements (IGA) with Washington State Federally Recognized tribes through the Office of Indian Policy (OIP)
- Personal service agreements made for services such as training for workforce development and capacity building

Most services provided are structured drug and alcohol prevention curriculum for youth (including drug-free activities) and parenting classes for adults. Services also include community organizing efforts and environmental strategies directed at prevention of substance use, policy change, drug education campaigns, and drug-free activities.

Tribal programs receive a set allocation based on a long-standing tribal enrollment calculation. The tribal government determines distribution for substance use disorder treatment services and prevention services. Funds allocated to the counties using county client service contracts focus on the identified CPWI community following a strategic plan approved by the state.

Each CPWI sub-recipient develops a local Strategic Plan. Tribes develop work plans that address local tribal needs and are reviewed and approved by the state prior to implementation. There are additional innovative programs supported with SABG funds at the local level all of which must follow the CSAP Principles of Effectiveness. The Strategic Action Plans use the Strategic Prevention Framework steps. Following a community needs and resource assessment, gaps analysis and prioritization process, the communities identify their local conditions and strategies. Strategic plans address each step of the Strategic Prevention Framework and include plans for cultural competence and capacity building within each step.

Workforce Capacity

DBHR has three major conference trainings. One, an annual Washington State Prevention Summit takes place in the fall and is attended by both youth and adults. This conference offers information on prevention research and practices as well as a forum for providers to develop new skills for implementing prevention services. Second, is the Summer Leadership Institute that is designed to enhance community coalition development and maintenance skills. The third conference specifically designed for youth, the annual Spring Youth Forum, where teams of students make presentations about

the projects that they planned during the training they received at the Prevention Summit the previous fall. Prevention providers associated with multiple state agencies participate in all of these conferences.

In addition to formal presentations and training opportunities, SAPT funds support six Prevention System Managers (PSM) in providing regular and timely technical assistance to the prevention workforce. The PSMs guide CPWI communities and Tribes in development of strategic plans, action plans, and SPF implementation. PSMs work with coalition coordinators to develop plans for communities to maintain compliance with their planned coalition activity. In partnership with Tribes, PSMs work on building plans that incorporate the adaptation of the SPF, innovative programs, and adaptations of Evidence-based programs for cultural inclusion and appropriateness.

Evidence-Based Programs

The state has an evidence-based workgroup that determines evidence-based practices and strategies for communities to consider during their planning phase of the SPF. Comprised of members from the prevention research sub-committee, SEOW, and academic partners, the group reviews evidence-based programs and practices that directly and indirectly affect youth substance use and misuse.

We have a standing Memorandum of Agreement with the SSA in Oregon State to maintain the evidence-based program and practices list that is posted on the Athena forum website.

http://www.theathenaforum.org/learning_library/ebp. The contract requires a minimum of 60% of prevention programs be evidence-based. Sub-recipients for primary prevention services select from this list.

The following table of evidence-based, primary prevention programs, practices and strategies is for implementation at the local level through the Community Coalitions and Tribal Nations.

<u>EBP Curriculum</u>	<u>CSAP Strategy</u>
Case Management	Alternative Activities
Children In Between	Prevention Education
Community Based Mentoring	Alternative Activities
Curriculum-Based Support Group (CBSG) Program	Prevention Education
Family Matters	Prevention Education
Girls Circle	Alternative Activities
Good Behavior Game (GBG)	Prevention Education
Guiding Good Choices	Prevention Education
Incredible Years	Prevention Education
Keep A Clear Mind (KACM)	Prevention Education
LifeSkills Training (LST)	Prevention Education
Lions Quest	Prevention Education
Love & Logic	Prevention Education
Media Detective	Prevention Education

Media Ready	Environmental
Mentoring: Big Brothers/Big Sisters	Alternative Activities
Nurse Family Partnership	Alternative Activities
Nurturing Parenting Programs	Prevention Education
PAL Peer Assistance and Leadership	Alternative Activities
Parenting Wisely	Prevention Education
Positive Action	Environmental
Power of Parents	Prevention Education
Project ALERT	Prevention Education
Project Northland	Prevention Education
Project SUCCESS	Prevention Education
Project Toward No Drug Abuse	Prevention Education
Protecting You/Protecting Me	Prevention Education
Reward & Reminder	Environmental
Say It Straight	Prevention Education
Second Step	Prevention Education
Sources of Strength	Prevention Education
SPORT	Prevention Education
Strengthening Families Program: For Parents and Youth 10-14	Prevention Education

Compliance Review

Monthly, DBHR uses the Prevention Management Information System (currently the Performance Based Prevention System (PBPS) to monitor service delivery against planned prevention programs and activities for compliance monitoring and determining the needs for technical assistance of prevention plan implementation. Annually, DBHR uses the Prevention Services Site Review Checklist to ensure compliance with DSHS contract and block grant requirements.

Prevention Services

Washington State’s Community Prevention and Wellness Initiative (CPWI) is a strategic, data-informed, community coalition model aimed at bringing together key local stakeholders to provide the needed 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 the Superintendent of Public Instruction (OSPI) for the placement of prevention/intervention specialists in schools to provide universal, selective, and indicated prevention and intervention services. Prevention/intervention specialists 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 prevention/intervention specialists also practice 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.

Prevention/Promotion

DBHR uses a risk and protective factor framework as the cornerstone of all prevention program investments. The implementation and delivery of 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).

The Community Prevention Wellness Initiative (CPWI) is a community-focused approach to substance use prevention in Washington State. It focuses limited public resources within high-need communities. These are communities have leaders who are committed to taking on the challenges of preventing substance use in their towns and neighborhoods. In many cases, they are rising to the challenge despite the enormous barriers created from multi-generational alcohol and other drug use and generational poverty (in many cases) that have left their communities with high rates of crime, poor school performance, and poor public health among many other high-risk community climate issues.

CPWI identifies and directs services to the highest need communities in each county. Components of the CPWI model include a community coalition comprised of representatives from multiple sectors relevant to prevention and the related consequences of use, staffing for that coalition, implementation of evidence-based practices for prevention, and a prevention and intervention specialist in the schools to provide early intervention services.

In addition to prevention programming, Tribal communities receive funding to implement Mental Health Promotion Projects within in their community. Each Tribe selects a program from an Evidence-based Program list that best fits the identified needs for their community. DBHR provides technical assistance in program selection, implementation, training, program adaption for cultural relevance and appropriateness, and reporting into the Performance Based Prevention System (PBPS).

Through a number of initiatives, DBHR supports mental health promotion and suicide prevention. In the past year, DBHR has facilitated Mental Health First Aid training for community members, for state employees not working in the behavioral health system, and for certified peer counselors. Enhancement grants to communities are for implementation of programs that promote mental health when the program aligns with the behavioral health outcomes identified in their strategic plans. DBHR encourages CPWI communities to utilize evidence-based and research-based programs that have ATOD prevention and mental health promotion outcomes.

Marijuana Legislation

Washington is one of 33 states, and the District of Columbia, that have passed legislation allowing the use of marijuana for medicinal purposes. Washington is also one of four states, and the District of Columbia, that allow recreational use of marijuana.

In 1998, voters approved Initiative 692 that permits the use of marijuana for medical purposes by qualifying patients. The Legislature subsequently amended the chapter on medical use of marijuana in 2007, 2010, and 2011, changing who may authorize the medical use of marijuana, the definition of

terminal or debilitating medical condition, what constitutes a 60-day supply of medical marijuana, and authorized qualifying patients and designated providers to participate in collective gardens.

In 2012, voters approved Initiative 502, which established a regulatory system for the production, processing, and distribution of limited amounts of marijuana for non-medical purposes. Under this system, the Liquor Cannabis Board (LCB) issues licenses to marijuana producers, processors, and retailers, and adopts standards for the regulation of these operations. The LCB establishes number of these licenses that issued. Persons age 21 years or older may purchase up to 1 ounce of useable marijuana, 16 ounces of solid marijuana-infused product, 72 ounces of liquid marijuana infused product, or seven grams of marijuana concentrates at a licensed retailer.

In 2015, Washington passed SB5519, the comprehensive marijuana reform act to combine the state regulatory system for medical and recreational marijuana.

The use of marijuana remains illegal under federal law. However, Congress in its 2015 fiscal year funding bill provided that the United States Department of Justice (DOJ) may not use federal funds to prevent states from carrying out their medical marijuana laws.

Additionally the DOJ issued several policy statements regarding state regulation of marijuana and describing when prosecutors may intervene. Federal prosecutors focus their investigative and prosecutorial resources on specific enforcement priorities to prevent the distribution of marijuana to minors, including: marijuana sales revenue from being directed to criminal enterprises; marijuana from being diverted from states where it is legal to states in which it is illegal; state-authorized marijuana activity from being used as a cover for trafficking other illegal drugs or other illegal activity; violence and the use of firearms in the production and distribution of marijuana; drugged driving and other marijuana-related public health consequences; the growth of marijuana on public lands; and marijuana possession or use on federal property.

Initiative 502 and amending law directs the Department of Social and Health Services (DSHS), Division of Behavioral Health and Recovery (DBHR) to:

- Conduct the Healthy Youth Survey (HYS)/Young Adult Survey.
- Develop, implement, maintain, and evaluate prevention and treatment programs and practices, mental health services for children and youth, and services for pregnant and parenting women.
- Provide marijuana prevention education to tribes for children and youth.

Of the funds appropriated for new programs and new services:

- Eighty-five percent of the funds must for evidence-based or research-based (EB/RB) programs and practices that produce objectively measurable result, and by September 1, 2020, are cost-beneficial.
- Up to 15 percent of the funds may be for proven and tested practices, emerging best practices, or promising practices.

For the 2015-17 Biennium, DBHR used specific appropriations for service enhancements and new programs. Additionally, a portion of the funds replaced services previously funded with other state or federal dollars. No appropriations were made prior to the 2015-17 Biennium.

QUALITY IMPROVEMENT PLAN

DBHR has a long-standing commitment to continuous quality improvement to ensure the best possible service delivery to its clients. DBHR's quality management program (QMP) provides a structure for system-wide quality improvement (QI) efforts and on-going evaluation of those efforts. Quality services are provided in a safe, effective, timely, equitable, and culturally competent manner. QI is the systematic use of data to improve client outcomes; to measure and assess the performance of behavioral health services and systems; to implement quality improvement initiatives; to improve contract performance, programs and services; and, to efficiently manage resources. The short- and long-term QI goals are derived from federal and state standards including 42 CFR 438, SAMHSA's National Behavioral Health Quality Framework (NBHQF), the BHSIA strategic plan and Results Washington, and DSHS Core Metrics, the WISe Quality Management Plan, annual review of EQRO findings and recommendations, legislative mandates including HB1519 and SB5732, and other identified improvement initiatives.

The QI Committee uses these criteria to prioritize performance measures:

- Relevance (is it important or meaningful?)
- Measurability (can the indicator realistically and efficiently be measured?)
- Improvability (can performance be better?) To determine this, current and historic baseline data will be collected. Improvement targets will be set.

Progress toward goals are reported throughout DBHR. The QI Committee (QIC) works in an inclusive and transparent manner to facilitate integration of improvement activities within DBHR and throughout the state's behavioral health system. The QI Committee recognizes the importance of bi-directional communication and engages partners in decision-making, prioritization and achievement of DBHR goals.

Partners include:

- Persons with lived experience and consumer groups
- Staff from the Governor's Office
- Staff from the Office of Financial Management
- Staff from Research and Data Analysis
- Tribes
- BHOs and Providers

The QIC reviews the Quality Management Plan annually and updates to reflect changing priorities.

CHILDREN AND ADOLESCENT BEHAVIORAL HEALTH SERVICES

Prevention/Early Identification

Administered by OSPI, federal Substance Abuse Prevention and Treatment block grant funds awards 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 work with designated school sites to provide direct services to students who are at risk and/or harmfully involved with alcohol, tobacco, and other drugs. SAPISP services include:

- Administer a uniform screening instrument to determine levels of substance abuse and mental health concerns.
- Individual and family counseling and interventions on student substance use.
- Peer support groups to address student and/or family substance abuse issues.
- Coordinate and make referrals to treatment and other social service providers.
- School-wide prevention activities that promote healthy messages and decrease substance use.

Behavioral Health Services

There is program agreement between local public mental health providers and local education agencies (LEAs) to coordinate activities that promote cross-systems collaboration 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.

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, starting with the integration of Mental Health and Substance Use Disorder in April 2016.
- Implementation of Wraparound with Intensive Services (WISe) emphasizes 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 problems in all domains.
- As a part of our Washington Administrative Code (WAC) 388-877-0620 related to Behavioral Health Services-Clinical the Individual Service Plan outlines components required for behavioral health treatment; including, but not limited to:
 - Completion and/or approval by a professional appropriately credentialed or qualified to provide mental health, chemical dependency, and/or problem and pathological gambling services
 - Addressing age, gender, cultural, strengths and/or disability issues identified by the individual or, if applicable, the individual's parent(s) or legal representative.
 - Use of terminology that is understandable to the individual and the individual's family.
 - Demonstration of the individual's participation in the development of the plan.

- Documentation of participation of family or significant others, if participation is requested by the individual and is clinically appropriate.
- Being strength-based.
- Containing measurable goals or objectives, or both.

The Family Youth System Partner Round Tables (FYSPRT) provide leadership at the regional and state level to influence the establishment and sustainability of Children’s Behavioral Health System of Care (SOC) values and principles in Washington. One of their primary responsibilities is statewide governance oversight of the SOC, Wraparound with Intensive Services, WISE, and the Recovery-Oriented Systems of Care (ROSCs) being developed in conjunction with State Adolescent Treatment Enhancement and Dissemination (SAT-ED) and State Youth Treatment – Implementation (SYT-IT). In collaboration with the SOC and SAT-ED/SYT-I Teams, the FYSPRT recommends strategies to improve behavioral health services and supports for children and youth as well as to monitor and review both process and outcome indicators. The FYSPRT supports and tracks the six goals of the Washington State SOC:

1. Infuse SOC values in all child-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 services provided in home-and community settings.
4. Develop and strengthen a workforce that will operationalize SOC values.
5. Build a strong data management system to inform decision-making and track outcomes.
6. Develop sustainable financing and align funding to ensure services are seamless for children, youth, and families.

The state collaborates with other child- and youth-serving agencies to address behavioral health needs. Coordinated contracts with Children’s Long Term Inpatient Program (CLIP) and the work of the CLIP Improvement Team is strengthened by the Children’s Behavioral Health Governance Structure which includes the Regional and Statewide FYSPRTs and the Systems of Care and TR Statewide, FYSPRT, and Executive Leadership Team (ELT) structures. The Statewide FYSPRT has participation from these six youth serving state partners; Rehabilitation Administration (RA), Department of Health, Children’s Administration, Health Care Authority, Office of Superintendent of Public Instruction, and Developmental Disabilities Administration. A tribal representative, Regional FYSPRT Tri-Leads and Division of Behavioral Health and Recovery representatives are also members of the Statewide FYSPRT.

Block Grant Funding provides ‘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 BH Oto further grow the workforce.

Contractors are required to implement at least 60 percent evidence-based programs and/or practices (EBPPs) and incorporated into the BHO contracts for children/youth. There is an expectation that the Behavioral Health Organizations will include this requirement by keeping the same language in the detailed plan.

Service utilization, costs, and outcomes for children and youth with mental, substance use, and co-occurring disorders are monitored and tracked through many different methods. These include:

- EBP reporting, and multiple input methods for WISE system rollout, and CANs progress tracking
- Payment system (ProviderOne)
- Performance based contracting and contract monitoring
- Children's Behavioral Health Measures
- Data systems reports

Co-occurring Treatment

There are two pilot projects (one rural, one urban) developed to address co-occurring disorders for students in a school-based setting. Office of Superintendent of Public Instruction is interested and tracking the projects in partnership. The projects focus on building capacity for the screening, assessment, referral, case management and treatment of students with co-occurring disorders for youth experiencing serious emotional disturbance. The projects enlist a mental health professional that is dually licensed for substance use disorder treatment or works in partnership with a CDP(T) DAn integral component of this project is training school staff in recognition of Mental Health and co-occurring symptom identification and response warning signs.

PREGNANT WOMEN AND WOMEN WITH DEPENDENT CHILDREN

Strategies for prioritizing pregnant women are contained within contract language between the state of Washington and PPW SUD providers. DBHR also provides each contractor with a priority population poster for the lobby of each agency.

Agencies work to get pregnant women into services within 24 hours. Interim services are provided when residential placement is not available. They enroll in outpatient treatment when residential services are not needed. 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 virus (HIV) and tuberculosis (TB) education.
- Referral for HIV or TB treatment services if necessary.

Pregnant and parenting women (PPW) and women with dependent children have priority access to DBHR-funded substance use disorder treatment services. PPW Residential substance use disorder treatment is available for women and their children under the age of six. Structured clinical services are provided in a 24-hour, live-in setting. PPW residential treatment offers an enhanced curriculum for high-risk women. Services may include a focus on domestic violence, childhood sexual abuse, mental health issues, employment skills, and education. The programs work to link women to prenatal and postnatal medical care, legal advocacy, and safe affordable housing. Residential Substance Use Disorder treatment is available for women and their children under the age of six. There are nine PPW residential providers.

Between May 2014 and April 2015 there were 352 PPW clients admitted to outpatient treatment. Relapse prevention strategies remain a primary focus of counseling. The continuum of care also includes activities designed to engage and connect individuals to recovery services, such as outreach, screening in healthcare (including referral to prenatal care) or other non-treatment settings, and case management services. Outpatient treatment patients are able to access Medicaid transportation as needed. None of our programs initiates MAT for their pregnant patients.

Recovery Housing_Support Services assists women who have completed primary treatment to maintain recovery and learn the skills they need to be nurturing parents and become financially self-sufficient. Services for women in a safe, clean and sober house include 24-hour non-clinical staff to provide a safe secure environment, transportation to other health care appointments, and child care staff. The alcohol- and drug-free residences provide recovery support and linkages to community-based services for women and their children through the Pregnant and Parenting Women (PPW) Housing Support Services. A care plan identifies community supports to maximize recovery. Case management coordinates outpatient substance use disorder treatment and facilitates prenatal and post-natal medical care, financial assistance, social services, vocational services, childcare needs, and permanent housing.

Therapeutic childcare is offered in nine PPW residential substance use disorder treatment settings

when children accompany their mother to treatment. These services are offered for the health and welfare of children at risk of abuse, neglect, and eventual substance use disorder. Services include developmental assessment, play therapy, behavioral modification, individual counseling, self-esteem-building activities, and family intervention to modify parenting behavior and to eliminate or prevent dysfunctional behavior by the child.

Safe Babies, Safe Moms, also known as the Comprehensive Program Evaluation Project (CPEP), serves substance using pregnant, postpartum, and parenting women (PPW) and their children from birth-to-three at sites in Snohomish, Whatcom, and Benton-Franklin counties. The program is a state-level consortium (DBHR, the Children's Administration and Economic Services Administration of DSHS, Health Care Authority, and the Department of Health) formed to respond to the disturbing number of births of alcohol- and drug-affected infants. Safe Babies, Safe Moms provides comprehensive services to stabilize women and their young children and supports women as they transition from public assistance to self-sufficiency.

The Parent Child Assistance Program (PCAP) provides advocacy services to high-risk, substance using pregnant and parenting women and their young children. Services include referral, support, and advocacy for substance abuse treatment and continuing care services. PCAP assists participants in accessing local resources such as family planning, safe housing, healthcare, domestic violence services, parent skills training, childcare, transportation, and legal services. This program supports linkages to healthcare and appropriate therapeutic interventions for children. PCAP is currently available in nine counties -.

STATE BEHAVIORAL HEALTH ADVISORY COUNCIL (BHAC)

The Division of Behavioral Health and Recovery is committed to creating an effective partnership with persons with lived experience to improve behavioral health services to persons living with mental and substance use disorders by improving the development, evaluation, and monitoring of those services by persons with lived experience and stakeholders.

DBHR has capitalized on the history of consumer involvement and established an integrated Behavioral Health Advisory Council (BHAC) in 2012. Their mission is to advise and educate the Division of Behavioral Health and Recovery, for planning and implementation of effective, integrated behavioral health services by promoting individual choice, prevention, and recovery in Washington State

It is DBHR's intent that BHAC be a policy partner with DBHR and would have a role in the key decisions that affect quality and effectiveness of the programs and services DBHR oversees, including problem gambling. Membership for this council meets the 51 percent consumer requirement, with an added goal of maintaining equal representation with the mental health and substance use disorder persons with lived experience. Representatives from other state agencies, BHOs, tribes, and providers are all active participants in the council.

Attachments

Table 1: Support Trainings

The Matrix Model	Moral Reconation Therapy (MRT)	Global Appraisal of Individual Needs (GAIN)
Mental Health First Aid	Crisis Response	Substance Abuse Prevention Skills Training
Enhancing Supervision Skills	Prevention Pathways	Medication Management
Ethics/Confidentiality	Cultural Diversity	Motivational Interviewing
Crisis Intervention	Non-Violent Crisis Intervention Training	Medication Assisted Treatment
Harm Reduction Approaches	Trauma Informed Care	

Table 2: BHAC Membership

Members	Representing
Connie Batin	Community Member
Carolyn Cox	Community Member
Cary Brim Reid	Community Member
Cathy Callahan Clem	Community Member
Colleen Haller	Community Member
Dakoda Foux	Community Member
Donald Bowen	Community Member
Heather Maxwell	Community Member
Jeff Adrich	Community Member
Jo Ellen Woodrow	Community Member
Kimberly Miller	Community Member
Kristina Sawyckyj-Moreland	Community Member
Linda Kehoe, Ed.D.	Community Member
Moira O'Crotty	Community Member
Myra Paull	Community Member
Phillip Gonzales	Community Member
Susan Kydd	Community Member
Vanessa Lewis	Community Member
Becky Bates	Provider
Mary O'Brien	Provider
Annabelle Payne	Provider
Beth Dannhardt	Provider
Steve Kutz	IPAC Tribal Representative
Brad Finegood	Behavioral Health Organization
Taku Mineshita	Children's Administration
Kathleen Arnold	Corrections
Marci Arthur	Developmental Disabilities
Tory Henderson	Health
Dan Halpin	Insurance Commissioner's Office
Pamala Sacks-Lawlar	Juvenile Rehabilitation
Kathy Morgan	Home/Community Services
Ron Hertel	Office of the Superintendent of Public Instruction
Kristin West	Problem Gambling
Vacant	Health Care Authority

Table 3: BHAC Membership by Composition Type

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Current Membership			Full Membership Needed for SUD/MH Balance	
Type	#	%		
Total Community	20	57%	3	58%
In recovery-CD	4	11%		
In recovery-MH	4	11%		
In recovery -Both	2			
Family-CD	1	3%	1	3%
Family-MH	2	6%		
Family - Both	4			
Parent-CD	1	3%		
Parent-MH	1	3%		
Youth - CD	0	0%	1	3%
Youth - MH	0	0%	1	3%
General Public	1			
Total State/Provider			1	3%
Leading State Experts	9	25%	1	3%
Tribal	1	3%		
Appointed BHO	1	6%		
Provider - CD	1	3%		
Provider - MH	1	3%		
Provider -Both	2	6%		
Total	35		40	

Current Ethnic Breakout		
Total Known	8	22%
Native American	1	13%
Asian/Pacific Islander	2	25%
Hispanic	3	38%
Black/African American	2	25%
<p>State Experts</p> <p>Mental Health</p> <p>Education</p> <p>Vocational Rehabilitation</p> <p>Criminal Justice</p> <p>Housing</p> <p>Social Services</p> <p>Substance Abuse</p> <p>Medicaid</p> <p>State Exchange</p>		