# Washington

# UNIFORM APPLICATION FY 2018/2019 - STATE BEHAVIORAL HEALTH ASSESSMENT AND PLAN

# SUBSTANCE ABUSE PREVENTION AND TREATMENT and

# COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

OMB - Approved 06/12/2015 - Expires 09/30/2020 (generated on 08/30/2017 4.04.53 PM)

# Center for Substance Abuse Prevention Division of State Programs

# Center for Substance Abuse Treatment Division of State and Community Assistance

and

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

# State Information

| State Information                |   |
|----------------------------------|---|
| Plan Year                        |   |
| Start Year                       | 2018  |
| End Year                         | 2019  |
| State SAPT DUNS I<br>Number      | Number<br>127347115   |
| Expiration Date                  |   |
|                                  | be the SAPT Grantee for the Block Grant<br>Department of Social and Health Services |
| Organizational Unit              | Behavioral Health Administration/Division of Behavioral Health and Recovery         |
| Mailing Address                  | PO Box 45330  |
| City                             | Olympia   |
| Zip Code                         | 98504-5330  |
| II. Contact Person<br>First Name | for the SAPT Grantee of the Block Grant<br>Chris                                    |
| Last Name                        | Imhoff  |
| Agency Name                      | Department of Social and Health Services  |
| Mailing Address                  | PO Box 45330  |
| City                             | Olympia   |
| Zip Code                         | 98504-5330  |
| Telephone                        | 360-725-3700  |
| Fax                              | 360-725-2280  |
| Email Address                    | imhofC@dshs.wa.gov  |
| State CMHS DUNS<br>Number        | Number<br>12734115  |
| Expiration Date                  |   |
|                                  | be the CMHS Grantee for the Block Grant<br>Department of Social and Health Services |
| Organizational Unit              | Behavioral Health Administration/Division of Behavioral Health and Recovery         |
| Mailing Address                  | PO Box 45330  |
| City                             | Olympia   |
| Zip Code                         | 98504-5330  |
| II. Contact Person<br>First Name | for the CMHS Grantee of the Block Grant<br>Chris                                    |
| Last Name                        | Imhoff  |
| Agency Name                      | Department of Social and Health Services  |

| City                                  | Olympia   |
|---------------------------------------|---|
| Zip Code                              | 98504-5330  |
| Telephone                             | 360-725-3770  |
| Fax                                   | 360-725-2280  |
| Email Address                         | imhofc@dshs.wa.gov  |
| III. State Expenditu<br>From          | re Period (Most recent State expenditure period that is closed out) |
| То                                    |   |
| IV. Date Submitted<br>Submission Date | 8/30/2017 4:03:35 PM  |

**Revision Date** 

# V. Contact Person Responsible for Application Submission

First Name Melissa

Last Name Clarey

Telephone 360-725-3532

Fax

Email Address claremm@dshs.wa.gov

Footnotes:

# 2017 Behavioral Health Organization Contacts Updated 3/7/2017

| Great Rivers BHO<br>Contacts:<br>Marc Bollinger<br>Brian Cameron  | Counties Served:<br>Telephone:<br>Email: | Cowlitz, Grays Harbor, Lewis, Pacific, Wahkiakum<br>1-360-795-5959 or 1-360-795-3126<br><u>MBollinger@greatriversbho.org</u> <u>bcameron@greatriversbho.org</u>       |
|---|--|---|
| Greater Columbia BHO<br>Contacts:<br>Troy Wilson<br>LeAnna Turner | Counties Served:<br>Telephone:<br>Email: | Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Klickitat, Walla<br>Walla, Whitman, Yakima<br>1-509-735-8681<br><u>TroyW@gcbh.org</u> <u>LeAnnaT@gcbh.org</u> |
| King County BHO<br>Contacts:<br>Kelli Nomura<br>Susan Mclaughlin  | Counties Served:<br>Telephone:<br>Email: | King<br>1-206-263-8087 or 1-206-296-0583<br><u>Kelli.Nomura@kingcounty.gov</u><br>susan.mclaughlin@kingcounty.gov   |
| North Central BHO<br>Contacts:<br>Tamara Burns                    | Counties Served:<br>Telephone:<br>Email: | Chelan, Douglas, Grant<br>1-509-886-6318 or 1-509-886-6320<br><u>tcardwell-burns@cdrsn.org</u>  |
| North Sound BHO<br>Contacts:<br>Joe Valentine<br>Annette Calder   | Counties Served:<br>Telephone:<br>Email: | Island, San Juan, Skagit, Snohomish, Whatcom<br>1-360-416-7013 or 1-800-684-3555<br>Joe Valentine@northsoundbho.org<br>Annette Calder@northsoundbho.org               |
| OptumHealth-<br>Pierce County BHO<br>Contacts:<br>Beatrice Dixon  | Counties Served:<br>Telephone:<br>Email: | Pierce<br>1-253-292-4203<br>Bea.dixon@optum.com   |
| Salish BHO<br>Contacts:<br>Anders Edgerton                        | Counties Served:<br>Telephone:<br>Email: | Clallam, Jefferson, Kitsap<br>1-360-337-4886 or 1-360-337-5721<br><u>aedgerton@co.kitsap.wa.us</u>  |

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|---|---|---------------------------------------|
| Spokane County<br>Regional BHO  | Telephone: 1-509-477-4510 or 1-509-4        | 177-7561                              |
| Contacts:   | Email: <u>cbarada@spokanecounty.</u>        | <u>org</u>                            |
| Christine Barada  | tstern@spokanecounty.or                     |                                       |
| Tonya Stern   |   |                                       |
|   |   |                                       |
|   | Counties Served: Mason, Thurston            |                                       |
| Thurston-Mason BHO  | Telephone: 1-360-867-2558 or 1-360-8        | 367-2562                              |
| Contacts:   | Email: <u>freedmm@co.thurston.wa</u>        | .us avalosj@co.thurston.wa.us         |
| Mark Freedman   |   |                                       |
| Joe Avalos  |   |                                       |

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|                              | Counties Served: | Clark, Skamania                      |
|------------------------------|------------------|--------------------------------------|
| Molina Healthcare MCO        | Telephone:       | 1-(800) 869-7175 ext. 147190         |
| Contact:                     | Email:           | Victoria. Evans@Molinahealthcare.com |
| Victoria Evans               |                  |                                      |
|                              |                  |                                      |
|                              | Counties Served: | Clark, Skamania                      |
| <b>Community Health Plan</b> | Telephone:       | 1-206-652-7204                       |
| of Washington MCO            | Email:           | Gabriel.Ayerza@chpw.org              |
| Contact:<br>Gabriel Ayerza   |                  | State.Programs@chpw.org              |
| Gabriel Ayerza               |                  |                                      |
|                              | Counties Served: | Clark, Skamania                      |
| <b>Beacon Health Options</b> | Telephone:       | 1-415-450-7942                       |
| ASO                          | Email:           | Sarah.Arnquist@beaconhs.com          |
| Contact:                     |                  |                                      |
| Sarah Arnquist               |                  |                                      |

# State Information

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

Fiscal Year 2018

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

|              | Title XIX, Part B, Subpart II of the Public Health Service Act               |                   |
|--------------|--|-------------------|
| Section      | Title  | Chapter           |
| Section 1921 | Formula Grants to States   | 42 USC § 300x-21  |
| Section 1922 | Certain Allocations  | 42 USC § 300x-22  |
| Section 1923 | Intravenous Substance Abuse  | 42 USC § 300x-23  |
| Section 1924 | Requirements Regarding Tuberculosis and Human Immunodeficiency Virus         | 42 USC § 300x-24  |
| Section 1925 | Group Homes for Recovering Substance Abusers                                 | 42 USC § 300x-25  |
| Section 1926 | State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18 | 42 USC § 300x-26  |
| Section 1927 | Treatment Services for Pregnant Women  | 42 USC § 300x-27  |
| Section 1928 | Additional Agreements  | 42 USC § 300x-28  |
| Section 1929 | Submission to Secretary of Statewide Assessment of Needs                     | 42 USC § 300x-29  |
| Section 1930 | Maintenance of Effort Regarding State Expenditures                           | 42 USC § 300x-30  |
| Section 1931 | Restrictions on Expenditure of Grant   | 42 USC § 300x-31  |
| Section 1932 | Application for Grant; Approval of State Plan                                | 42 USC § 300x-32  |
| Section 1935 | Core Data Set  | 42 USC § 300x-35  |
|              | Title XIX, Part B, Subpart III of the Public Health Service Act              |                   |
| Section 1941 | Opportunity for Public Comment on State Plans                                | 42 USC § 300x-51  |
| Section 1942 | Requirement of Reports and Audits by States                                  | 42 USC § 300x-52  |
| Section 19/3 | Additional Poquirements  | 42 LISC & 300x 53 |

Section 1943 Additional Requirements Printed: 8/30/2017 4:04 PM - Washington - OMB No. 0930-0168 Approved: 06/12/2015 Expires: 09/30/2020

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

# ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

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

(Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seg.); (g) Printed: 8/30/2017 4:04 PM - Washington - OMB No. 0930-0168 Approved: 06/12/2015 Expires: 09/30/2020 Page 7 of 286

protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

- 12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
- 13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
- 14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
- 15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance. 16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
- 16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
- 17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

# LIST of CERTIFICATIONS

## 1. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93). By signing and submitting this application, the applicant is providing certification set out in Appendix A to 45 CFR Part 93.

## 2. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

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

## 3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

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

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

The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

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

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

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

Name of Chief Executive Officer (CEO) or Designee: Chris Imhoff

Signature of CEO or Designee<sup>1</sup>:

Title: Director

Date Signed:

mm/dd/yyyy

# Footnotes:



# STATE OF WASHINGTON DEPARTMENT OF SOCIAL AND HEALTH SERVICES PO Box 45010, Olympia, Washington 98504-5010

May 25, 2017

Virginia Simmons Grants Management Officer Division of Grants Management Substance Abuse and Mental Health Services Administration 1 Choke Cherry, Room 7-1103 Rockville, MD 20850

Dear Ms. Simmons:

I hereby delegate Chris Imhoff, Director, Division of Behavioral Health and Recovery of the Washington State Department of Social and Health Services, Behavioral Health Administration, the authority to act on my behalf in making application, reports (including Synar), and certifications related to the Unified Block Grant for the Substance Abuse Prevention and Treatment Block Grant and the Community Mental Health Services Block Grant administered by the United States Department of Health and Human Services. This delegation of authority is effective immediately and shall apply to any requirements for release of funds and other assistance necessary to implement or manage the grant process.

Your assistance with this matter is appreciated.

Sincerely,

Bill Moss Acting Secretary

**DSHS:** Transforming Lives

cc:

Chris Imhoff, Director, Division of Behavioral Health and Recovery Ginger Stewart, Finance Director, Behavioral Health Administration Melissa Clarey, Block Grant Administrator, Division of Behavioral Health and Recovery JAY INSLEE Governor



May 26, 2017

Ms. Virginia Simmons Grants Management Officer Division of Grants Management Substance Abuse and Mental Health Services Administration 1 Choke Cherry, Room 7-1103 Rockville, Maryland 20850

Dear Ms. Simmons:

With this letter, I hereby delegate to Bill Moss, Acting Secretary of the Department of Social and Health Services, the authority to act on my behalf in making application, certifications, and reports (including Synar) related to the Unified Block Grant for the Substance Abuse Prevention and Treatment Block Grant and the Community Mental Health Services Block Grant administered by the United States Department of Health and Human Services. This delegation of authority is effective immediately and shall apply to any requirements for release of funds and other assistance necessary to implement or manage the grant process.

Your assistance with this matter is greatly appreciated.

Very truly yours,

Anh slee

cc: Bill Moss, Acting Secretary, Department of Social and Health Services

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# **State Information**

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

Fiscal Year 2018

U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administrations Funding Agreements as required by Substance Abuse Prevention and Treatment Block Grant Program as authorized by Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act and

Tile 42, Chapter 6A, Subchapter XVII of the United States Code

|              | Title XIX, Part B, Subpart II of the Public Health Service Act               |                   |
|--------------|--|-------------------|
| Section      | Title  | Chapter           |
| Section 1921 | Formula Grants to States   | 42 USC § 300x-21  |
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| Section 1923 | Intravenous Substance Abuse  | 42 USC § 300x-23  |
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| Section 1925 | Group Homes for Recovering Substance Abusers                                 | 42 USC § 300x-25  |
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| Section 1930 | Maintenance of Effort Regarding State Expenditures                           | 42 USC § 300x-30  |
| Section 1931 | Restrictions on Expenditure of Grant   | 42 USC § 300x-31  |
| Section 1932 | Application for Grant; Approval of State Plan                                | 42 USC § 300x-32  |
| Section 1935 | Core Data Set  | 42 USC § 300x-35  |
|              | Title XIX, Part B, Subpart III of the Public Health Service Act              |                   |
| Section 1941 | Opportunity for Public Comment on State Plans                                | 42 USC § 300x-51  |
| Section 1942 | Requirement of Reports and Audits by States                                  | 42 USC § 300x-52  |
| c (1 1040    |  | 42 LISC & 200y-52 |

Section 1943 Additional Requirements Printed: 7/13/2017 5:08 PM - Washington Printed: 8/30/2017 4:04 PM - Washington - OMB No. 0930-0168 Approved: 06/12/2015 Expires: 09/30/2020

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

# **ASSURANCES - NON-CONSTRUCTION PROGRAMS**

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

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

- 1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
- 2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
- 3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
- 4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
- 5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
- 6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §\$1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §\$794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §\$6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §\$523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §\$290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §\$3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
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Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

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

| Name of Chief Executive O | Officer (CEO) or Designee: | Chris Imhoff |
|---------------------------|----------------------------|--------------|

Signature of CEO or Designee<sup>1</sup>:

Title: Director

Date Signed: <u>81117</u>

mm/dd/yyyy

<sup>1</sup>If the agreement is signed by an authorized designee, a copy of the designation must be attached. Printed: 7/13/2017 5:08 PM - Washington Printed: 8/30/2017 4:04 PM - Washington - OMB No. 0930-0168 Approved: 06/12/2015 Expires: 09/30/2020

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#### Footnotes:

# State Information

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

Fiscal Year 2018

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

- 1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
- 2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
- 3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
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Name of Chief Executive Officer (CEO) or Designee: Chris Imhoff

Signature of CEO or Designee<sup>1</sup>:

Title: Director

Date Signed:

mm/dd/yyyy

# Footnotes:

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Fiscal Year 2018

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Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93). By signing and submitting this application, the applicant is providing certification set out in Appendix A to 45 CFR Part 93.

#### 2. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

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

#### 3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

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

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

The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

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

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

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

| Name of Chief Executive Officer (CEO) or Designee: Chris Imhoff |              |       |  |  |  |  |  |  |
|---|--------------|-------|--|--|--|--|--|--|
| Signature of CEO or Designee <sup>1</sup> :                     |              |       |  |  |  |  |  |  |
| Title: Director   | Date Signed: | 81117 |  |  |  |  |  |  |
|   | Date signed. | 0.,,  |  |  |  |  |  |  |

mm/dd/yyyy

<sup>1</sup>If the agreement is signed by an authorized designee. a copy of the designation must be attached. Printed: 7/13/2017 5:08 PM - Washington Printed: 8/30/2017 4:04 PM - Washington - OMB No. 0930-0168 Approved: 06/12/2015 Expires: 09/30/2020

Page 4 of 5 Page 27 of 286 JAY INSLEE Governor



May 26, 2017

Ms. Virginia Simmons Grants Management Officer Division of Grants Management Substance Abuse and Mental Health Services Administration 1 Choke Cherry, Room 7-1103 Rockville, Maryland 20850

Dear Ms. Simmons:

With this letter, I hereby delegate to Bill Moss, Acting Secretary of the Department of Social and Health Services, the authority to act on my behalf in making application, certifications, and reports (including Synar) related to the Unified Block Grant for the Substance Abuse Prevention and Treatment Block Grant and the Community Mental Health Services Block Grant administered by the United States Department of Health and Human Services. This delegation of authority is effective immediately and shall apply to any requirements for release of funds and other assistance necessary to implement or manage the grant process.

Your assistance with this matter is greatly appreciated.

Very truly yours,

Anh slee

cc: Bill Moss, Acting Secretary, Department of Social and Health Services

@ calification



# STATE OF WASHINGTON DEPARTMENT OF SOCIAL AND HEALTH SERVICES PO Box 45010, Olympia, Washington 98504-5010

May 25, 2017

Virginia Simmons Grants Management Officer Division of Grants Management Substance Abuse and Mental Health Services Administration 1 Choke Cherry, Room 7-1103 Rockville, MD 20850

Dear Ms. Simmons:

I hereby delegate Chris Imhoff, Director, Division of Behavioral Health and Recovery of the Washington State Department of Social and Health Services, Behavioral Health Administration, the authority to act on my behalf in making application, reports (including Synar), and certifications related to the Unified Block Grant for the Substance Abuse Prevention and Treatment Block Grant and the Community Mental Health Services Block Grant administered by the United States Department of Health and Human Services. This delegation of authority is effective immediately and shall apply to any requirements for release of funds and other assistance necessary to implement or manage the grant process.

Your assistance with this matter is appreciated.

Sincerely,

Bill Moss Acting Secretary

**DSHS:** Transforming Lives

cc:

Chris Imhoff, Director, Division of Behavioral Health and Recovery Ginger Stewart, Finance Director, Behavioral Health Administration Melissa Clarey, Block Grant Administrator, Division of Behavioral Health and Recovery

# State Information

# Disclosure of Lobbying Activities

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

| Name         |  |  |  |
|--------------|--|--|--|
| Title        |  |  |  |
| Organization |  |  |  |
|              |  |  |  |

Signature:

Date:

Footnotes:

# **Planning Steps**

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

Narrative Question:

Provide an overview of the state's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA, and other state agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, tribal, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic, and sexual gender minorities, as well as American Indian/Alaskan Native populations in the states.

Footnotes:

# ASSESS THE STRENGTH AND NEEDS OF THE BEHAVIORAL HEALTH SYSTEM

The Department of Social and Health Services (DSHS) is one of Washington's largest state agencies and houses the majority of the 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.

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, DSHS 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.

BHA includes the Division of Behavioral Health and Recovery (DBHR), the Office of Forensic Mental Health Services, two state psychiatric hospitals (Eastern and Western State hospitals) and the Child and Study Treatment Center. BHA's core services focus on:

- <u>Individual Support</u> 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.
- <u>Health Care Quality and Costs</u> 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.
- <u>Administration</u> Providing management infrastructure to support administrative functions such as accounting, fiscal, forecasting, contracting, and information technology for BHA.

BHA operates two state psychiatric hospitals that deliver inpatient psychiatric care to adults who have been committed through the civil or criminal court system for treatment and/or competency restoration services. BHA also operates the Child Study and Treatment Center that provides high-quality inpatient psychiatric care and education to children ages 5 to 18 who cannot be served in less restrictive settings in the community due to their complex needs. The two state hospitals and the Child Study and Treatment Center have a combined inpatient capacity to serve 1,200 patients. In addition to providing inpatient services, the hospitals also provide outpatient forensic services to individuals who are waiting for an evaluation or for whom the courts have ordered an out-of-custody competency evaluation.

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

• Substance Use Disorder Prevention

- Intervention
- Outpatient substance use disorder and mental health services
- Inpatient/residential substance use disorder and mental health services
- Substance use disorder prevention services
- Mental health promotion (funded with GF-State)
- Recovery support services
- Pathological and problem gambling services

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

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

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

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

- Building on a continuum of services including prevention, intervention, treatment, and recovery support, which incorporate evidence-based programs and practices whenever possible.
- Implementation of a fee-for-service program for American Indian (AI)/Alaskan Natives (AN) for substance use disorder and mental health treatment services.
- Develop cross agency strategies for opiate substitution treatment by securing several federal grants to address the opioid crisis.
- Develop a plan, process, and structure that supports treatment and recovery for individuals who experience a substance use and mental health disorder. Individuals who experience a co-occurring disorder (COD) have one or more substance use related disorders as well as one or more mental health related disorders.
- Implementation of Secure Withdrawal Management and Stabilization Facilities.
- Expanding to full integration with primary care by 2020 with early and mid-adopter regions during the time until full implementation.

DBHR provides prevention, intervention, inpatient treatment, outpatient treatment, and recovery support to people who are risk for addiction or diagnosed with mental illness. In calendar year 2016:

- 197,649 clients participated in mental health treatment (35,729 received crisis services).
- 64,944 clients participated in substance use disorder treatment.
- 16,918 clients received direct services with community strategies reaching over 100,000 clients with substance use disorder prevention activities.
- 418 clients participated in pathological and problem gambling treatment.

The total current 2017-19 biennial budget for Mental Health community services is \$1,906,642,000 of this amount:

- GF-State \$821,305,000
- Federal Discretionary Funds \$55,512,000
- Local \$18,366,000
- Medicaid \$1,004,091,000
- Designated Marijuana Account \$7,368,000

Currently, based on the President's budget, \$1.0 million of the MHBG funds are set aside for First Episode Psychosis (FEP) and \$1.0 million of MHBG funds are set aside for the Children's 10 percent set aside requirement.

The total current 2017-19 biennial budget for Alcohol and Substance Abuse is \$809,645,000 of this amount:

- GF-State \$150,150,000
- Federal Discretionary Funds \$106,559,000
- Local \$20,211,000
- Medicaid \$468,690,000
- Criminal Justice Treatment Account \$12,978,000
- Problem Gambling \$1,453,000
- Designated Marijuana Account \$49,604,000

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

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

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

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

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

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

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

# CONTRACTING OF THE PUBLIC BEHAVIORAL HEALTH SYSTEM

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

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

# **Behavioral Health Organizations (BHO)**

As required by the Washington State Legislature, the substance use disorder (SUD) and mental health (MH) services were integrated into a behavioral health managed care benefit on April 1, 2016. This required the formation of regional BHOs that have at-risk contracts to deliver both substance use disorder and mental health services also known as Prepaid Inpatient Health Plans (PIHPs). The BHOs contract for direct services with local providers to provide an array of behavioral health services based

on medical necessity, oversee the distribution of funds under the state managed care plan, provide utilization management and other administrative functions, and develop quality improvement and enrollee protections for all Medicaid clients enrolled in the BHO system. The capitated managed care behavioral health system gives the BHOs the ability to design an integrated system of mental health and substance use disorder care and subcontract with networks of community behavioral health agencies capable of providing high quality service delivery, which are age appropriate and culturally competent. This contractual structure is expected to improve behavioral health service outcomes and help to control the rate of financial growth while still requiring adherence to all state and federal requirements. BHOs may impose additional requirements on subcontractors as needed to ensure appropriate management oversight and flexibility in addressing local needs.

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

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

## Fully Integrated Manage Care (FIMC)

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

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

The expectation is that over the next three years other regions will be added to the fully integrated program. Starting with the North Central Region in January 2018, which includes three counties, Chelan, Douglas and Grant. The state is in conversations with other regions in an effort to identify transition dates in order to accomplish statewide full integration in 2020. The state received resources through the Medicaid 1115 waiver that will increase the pace of integration.

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

## State Tribal Agreements and Contracts with Tribes

DBHR continues to provide funding opportunities for tribes to support substance use disorder prevention and treatment programs and to enhance mental health services administered by the tribes.

Specifically, the Consolidated Contract between DSHS and each individual Tribe is for services provided in a tribal behavioral health program. This contract includes two funding sources with separate reporting structures. The largest portion of the contract is funded with the SABG, and the Tribes receive two additional mini-grants funded through the State Legislature (Mental Health Promotion Projects and the Dedicated Marijuana Funds Account). These contracts provide financial support for the 29 Federally Recognized Tribes for culturally based treatment services and/or prevention activities. Tribal programs provide services mainly to the tribal populations, but the Tribes can also serve non-tribal members. It is important to note that Tribes are not required to participate in the Consolidated Contract.

Since July 1997, DBHR has been able to provide funds to the Federally Recognized Tribes in Washington State to support the delivery of outpatient treatment services by tribal facilities and community-based prevention activities to tribal members. Each tribe receives a base of \$57,499 per biennium, the remaining \$1.4 million in funding is allocated to the tribes based on a methodology of 30 percent on population and 70 percent is distributed evenly between the tribes.

Not only can Tribes contract with DBHR, but Tribes also have the opportunity and option to contract with the BHOs. DBHR contracts with nine BHOs across the state to provide outpatient and residential SUD and MH services. Tribes have the opportunity to contract with any BHO to provide outpatient and/or residential SUD and MH services to individuals in their communities. These contracting opportunities are available to the Urban Indian Health Programs as well. These contracts are negotiated between the BHO and the Tribe or Urban Indian Health Program.

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.

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

Recently DBHR, HCA, Indian Health Services (IHS) Direct, Tribal 638, and Urban Indian Health Programs (I/T/U) system of care worked together to implement the fee-for-service system for SUD and MH treatment services for AI/AN individuals covered by Medicaid. Medicaid funding pays for outpatient and residential SUD and MH services for these clients who receive these services from a fee-for-service (FFS) provider. For those AI/AN clients who are non-Medicaid, they are able to receive services from their tribal behavioral health provider and/or from a non-tribal provider within the BHO system of providers. BHOs also use block grant funding to pay for the SUD and MH services for these non-Medicaid clients.

## **Primary Prevention Services**

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

Most services provided are structured evidence-based drug and alcohol prevention curriculum for youth and parenting classes for adults. Information dissemination efforts and alternative drug-free activities are permitted as part of comprehensive program plans. Services also include community organizing efforts and environmental strategies that impact policy, community norms, access and availability of substances and enforcement of policies directed at substance use prevention. DBHR leads and engages in several state-wide collaborative efforts that focus on workforce development; planning and data collection for youth and young adults; mental health promotion; and prevention of underage drinking, youth marijuana use, prescription and opioid misuse and abuse.

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

DBHR contracts with the Office of Superintendent of Public Instruction (OSPI) for the placement of Prevention/Intervention (P/I) specialists in schools to provide universal, selective, and indicated prevention and intervention services. P/I 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 P/I 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 that have a PIS in place are implementing Project SUCCESS. Project SUCCESS is a model for prevention intervention (PI) used statewide in Washington State. Funds support PI staff time in a school to provide both prevention and intervention services. A tribal PIS presented about Project SUCCESS at DBHRs Tribal Prevention Learning Community meeting. More detail is available in the <u>Project SUCCESS link</u>.

Washington State's community-based organizations (CBOs) grantees serve high-need communities to provide quality and culturally competent replications of evidence-based, research-based, and promising substance use prevention programs. This statewide process provides services using the list of approved prevention programs within defined percentages. Organizations are encouraged to partner with Community Prevention and Wellness Initiative (CPWI) community coalitions or other existing

community coalitions when possible, and follow the same reporting requirements as current prevention service providers.

## ADULT BEHAVIORAL HEALTH SYSTEM

## Mental Health

The BHOs and the FIMC, through contracts with community mental health agencies, provide a complete array of services to adults with serious mental illness (SMI) who meet the Access to Care standards (diagnosis and level of functional impairment) and standardized medical necessity criteria. 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 and FIMC contracts with provider groups and community mental health agencies. Each BHO and FIMC network serves all Medicaid enrollees within its geographical area. Crisis services are available to all residents of the state, without regard to funding or Medicaid eligibility.

The BHOs and ASO administer the Involuntary Treatment Act (ITA) and the crisis response system for all people in their service area, regardless of income or eligibility. In most communities, crisis and involuntary services are highly integrated. Crisis services include a 24-hour crisis line and in-person evaluations for those presenting with mental health crises. Crises are to be resolved in the least restrictive manner and should include family and significant others as appropriate and at the request of the consumer. ITA services include in-person investigation of the need for involuntary inpatient care. A person must meet legal criteria and refused or failed to accept less restrictive alternatives to be involuntarily detained.

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

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

## Substance Use Disorder Treatment

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

Each BHO contracts with provider groups and community substance use disorder agencies. Each BHO and FIMC serves all Medicaid enrollees within its geographical area except for AI/AN who have opted

out of receiving SUD services through the BHOs but instead have opted to receive services through the fee-for-service delivery system.

Intensive residential and outpatient treatment for substance use disorder includes counseling services and education. Some patients receive only outpatient or intensive outpatient treatment. Other patients transfer to outpatient treatment after completing intensive residential services. Relapse prevention strategies remain a primary focus of counseling. There are currently three types of residential substance use disorder treatment settings for adults in the state:

- Intensive inpatient treatment provides a concentrated program of individual and group counseling, education, and activities for people who are addicted to substances and their families. There are currently 69 intensive inpatient residential providers with a total capacity of 2,146 beds. The BHOs may subcontract for intensive inpatient services. Each patient participating in this level of substance use disorder treatment receives a minimum of 20 hours of treatment services each week.
- Long-term residential treatment provides treatment for the chronically impaired adult with impaired self-maintenance capabilities. There are currently seven adult long-term residential providers with a total capacity of 135 beds. Each patient participating in this level of substance use disorder treatment receives a minimum of four hours of treatment per week.
- Recovery Houses provide personal care and treatment, with social, vocational, and recreational
  activities to aid with patient adjustment to abstinence, as well as job training, employment, or
  other community activities. There are currently five adult recovery house providers with a
  capacity of 58 beds statewide. Each patient participating in this level of substance use disorder
  treatment receives a minimum of five hours of treatment services per week.

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

- Sub-acute Detox are clinically managed residential facilities that have limited medical coverage. Staff and counselors monitor patients and any treatment medications are self-administered.
- Acute Detox are medically monitored inpatient programs that have medical coverage by nurses and physicians who are on-call 24/7 for consultation. They have "standing orders" and available medications to help with withdrawal symptoms. They are not hospitals but have referral relationships with them.
- Acute Hospital Detox is medically managed intensive inpatient that have medical coverage by registered nurses and nurses with doctors available 24/7. There is full access to medical acute care including the intensive care unit if needed. Doctors, nurses, and counselors work as a part of an interdisciplinary team who medically manage the care of the patient. This level of care is considered hospital care and is not part of the behavioral health benefits provided through the BHOs or MCOs.

## CHILDREN AND YOUTH BEHAVIORAL HEALTH SYSTEM

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

- Legislative direction for the creation of Behavioral Health Organizations which began in April 2016. Behavioral Health Organizations took lead in integrating Substance Use Disorder services into managed care with mental health services. This process is the first step to full purchasing integration with physical and behavioral health services.
- Implementation of Wraparound with Intensive Services (WISe) emphasizes a wraparound approach to both high-level and other level need youth cases, adopting the Child and Adolescent Needs and Strengths (CANS) assessment tool to evaluate needs and strengths in multiple domains. Access to Care Standards highlights the need to evaluate functional need in all domains.
- Washington State's First Episode Psychosis Initiative, placing emphasis on early intervention services for individuals experiencing early onset symptoms of schizophrenia.
- Family Peer Partner and Youth Peer Partner development in services and system development.
- As a part of our Washington Administrative Code (WAC) 388-877-0620 Clinical Individual Service Plan outlines components required for mental health and substance use disorder treatment; including, but not limited to:
  - Address age, gender, cultural, strengths and/or disability issues identified by the individual or, if applicable, the individual's parent(s) or legal representative.
  - Use a terminology that is understandable to the individual and the individual's family.
  - Demonstrate the individual's participation in the development of the plan.
  - Document participation of family or significant others, if participation is requested by the individual and is clinically appropriate.
  - Be strength-based.
  - Contain measurable goals or objectives, or both.

The state has established collaborations with other child and youth serving agencies in the state to address behavioral health needs as evidenced by the coordinated contracts with Children's Long Term Inpatient Program (CLIP) and Behavioral Health Organization regions. This effort has been strengthened by the System of Care Grant and T.R. Settlement driven Children's Behavioral Health Governance Structure including the Children's Behavioral Health Executive Leadership Team, the Statewide FYSPRT, and ten Regional FYSPRTs. The Statewide FYSPRT has a tribal representative and representatives from these six youth-serving state partners: Rehabilitation Administration-Juvenile Rehabilitation (RA), Department of Health (DOH), Children's Administration (CA), Health Care Authority (HCA), Office of Superintendent of Public Instruction (OSPI), and Developmental Disabilities Administration (DDA).

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

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

by the end of 2019, the percentage of EBPP services for children and youth will be no lower than 45 percent per region.

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

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

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

## Mental Health Services

A program agreement was established to coordinate activities that promote cross-systems collaboration between local public mental health providers and local education agencies (LEAs) to provide services and programs for students who are eligible for special education services under the Individuals with Disabilities Education Act (IDEA) and who are eligible for services through the DBHR.

## Treatment

In 2015, two counties (one rural, one urban) piloted a project to address co-occurring disorders for students in a school-based setting. This project was in concert with the Office of Public School Instruction and focused on building capacity for the screening, assessment, referral, case management, and treatment to students with co-occurring disorders. This project enlisted a mental health professional, under the direct clinical supervision of a dually licensed chemical dependency and mental health professional, to serve a minimum of 50 youth with co-occurring needs. The direct services delivered are based on best practices identified by the University of Washington Evidence-Based Practice Institute.

## AN OVERVIEW OF THE CONTINUUM OF CARE

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

## Prevention/Mental Health Promotion

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

## Intervention

Washington has had success with an implementation of the Screening and Brief Intervention grant. The original Washington State SBIRT project (WASBIRT) found that providing SBIRT services in hospital emergency departments was associated with reductions in medical costs of \$366 per member per month for Medicaid patients (Estee, et al., 2010). There have also been some tribal medical staff who have become SBIRT certified.

## Mental Health Treatment

DBHR funds the BHO and FIMC to provide an integrated public mental health treatment system for persons experiencing mental illness who are enrolled in Medicaid and meet the statutory need definitions for those experiencing a mental health crisis and for those who are deemed a danger to themselves or others due to a mental disorder. Medical necessity and Access to Care Standards (ACS), established by the department and approved by the Centers for Medicare and Medicaid Services (CMS), govern access to services for mental health. In general, to meet the ACS criteria, a person must have a covered diagnosis, significant functional impairment, and the requested service is reasonably expected to improve, stabilize, or prevent deterioration of functioning resulting from the presence of a mental illness.

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

## **Crisis Services**

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

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

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

Effective April 1, 2018, Designated Mental Health Professionals will become Designated Crisis Responders and will have the authority to detain individuals due to mental health disorder or a substance use disorder under RCW 71.05. Individuals detained due to a substance use disorder will be detained to a secure detoxification facility. RCW 70.96A and the role and functions of the Designated Chemical Dependency Specialist will expire April 1, 2018.

If an AI/AN who is served by a tribal behavioral health provider is in crisis, DBHR requires that the BHOs coordinate with the tribal behavioral health provider to provide continuing services during and after the crisis. This is contingent upon the AI/AN client signing a release of information.

## Substance Use Disorder Treatment

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 the 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).

## Pregnant Women and Women with Dependent Children

The Pregnant and Parenting Housing Support Services provides housing support services for woman who are pregnant, postpartum, or parenting women with children in drug and alcohol-free residences for up to 18 months. A care plan is developed for clients that identifies community supports to maximize recovery. Case Managers coordinate outpatient substance use disorder treatment and facilitate prenatal and post-natal medical care, financial assistance, social services, vocational services, childcare needs, and permanent housing.

Therapeutic Intervention for Children services provides for children of parents receiving residential substance use disorder services. Services are for care, protection, and treatment of children who are at risk of abuse, neglect and eventual substance abuse. Services includes: developmental assessments, play therapy, behavioral modification, individual counseling, self-esteem and family intervention to modify parenting behavioral and/or the child's environment to eliminate/prevent the child's dysfunctional behavior. Childcare is provided at nine Pregnant and Parenting Women (PPW) residential substance use disorder treatment settings when children accompany their mother to treatment.

The Parent Child Assistance Program (PCAP) provides advocacy services to high-risk, substance-abusing 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, health care, domestic violence services, parent skills training, childcare, transportation, and legal services. This program supports linkages to health care and appropriate therapeutic interventions for children. PCAP is currently available in nine counties.

The Washington State Fetal Alcohol Syndrome Diagnostic and Prevention Network (WA FASDPN) includes two community-based interdisciplinary fetal alcohol spectrum disorder (FASD) diagnostic clinics in Yakima and Everett, linked by the core clinical/research/training program at the University of Washington. The mission of the WA FASDPN is FASD prevention through screening, diagnosis, intervention, research, and training. The WA FASDPN:

- Provides 100 percent of the state's interdisciplinary FASD diagnostic and treatment referral services to individuals of all ages with fetal alcohol exposure.
- Provides FAS screening and surveillance for high-risk populations.
- Identifies and refers high-risk women to intervention programs.
- Develops FASD screening, diagnostic, and intervention tools through its translational research program.
- Provides FASD training to community professionals.
- Is recognized as a national/international model for FASD diagnosis and prevention. This program has been replicated worldwide.

## Pathological and Problem Gambling

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

## Office of Consumer Partnership

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

- Providing leadership as a member of the Executive Management Team.
- Advocating for both substance use disorder and mental health individuals with lived experience.
- Ensuring, by policy and contractual requirements, that advisory committees and planning groups include meaningful consumer voice.
- Assisting in the development and support of emerging consumer leadership.
- Supporting consumer networking and leadership training at DBHR-supported conferences and trainings. Assisting with recovery-oriented training, including 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.

## WORKFORCE DEVELOPMENT

## Tribal Behavioral Health Conference

Washington maintains a Government to Government relationship with Federally Recognized Tribes. As the state transitions into managed care, and the tribal behavioral health system remains a fee-forservice system, ongoing communication collaboration, and education for tribal and non-tribal providers is essential. In light of this, the American Indian Health Commission sent a request on March 1, 2017, to DSHS and the Health Care Authority for funding to sponsor a tribal behavioral health conference to help educate those involved in the upcoming fee-for-service transition for mental health services. The purpose of the Tribal Behavioral Health Conference is to provide a forum for health professionals from Tribes, Urban Indian Health Organizations, all Indian Health Care Providers, Behavioral Health Organizations, Community Mental Health Agencies, Accountable Communities of Health, and others to share best practices for the delivery of mental health and substance use disorder treatment services for American Indians (AI) and Alaska Natives (AN) in Washington State, as well as providing a forum to discuss the legislatively-driven directive to integrate behavioral health and physical health services by 2020. Topic areas included:

- July 1, 2017 implementation of Medicaid mental health fee for service benefits
- Clinical models
- Operational approaches
- Financial strategies

DBHR provides funding for five annual statewide conferences and trainings:

## **Co-Occurring Disorder Conference**

The annual Washington State COD and Treatment Conference will be held in Yakima at the Convention Center on October 16 and 17, 2017. Ethics and Suicide Prevention will be provided on October 15, 2017. The conference provides attendees (including consumer and family) with information regarding current legislation related to mental health care and services, current resources, and treatment methodologies.

This year, the COD conference plenary sessions focus on Trauma, The Effects of Cannabis and Cannabinoids, Medication Assisted Therapies, and Developmental Disabilities. In addition, the plenary focus areas will also have workshops addressing Motivational Interviewing, Trauma, Medication Assisted Therapies, youth and gender issues, special populations, and workforce development. The conference also provides opportunities for participants to network with other service providers, state representatives, other families, and individuals with COD.

## Saying it Out Loud Conference

The Saying it Out Loud (SIOL) Conference is planned in partnership with the Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) communities and other DSHS Administrations (Behavioral Health Administration, Rehabilitation Administration, and the Aging and Long-Term Support Administration) This conference brings together professionals from the diverse fields of social work, mental health, substance use disorder treatment, and substance abuse prevention to focus on the impacts of substance use disorder and mental health on LGBTQ individuals and communities. DSHS has a long-standing record of supporting and partnering with the LGBTQ community.

This year's conference was at the Greater Tacoma Convention and Trade Center on Monday, May 22, 2017, there were approximately 350-400 attendees from around the state of Washington. The keynote, Harlan Pruden spoke to the Two-Spirit Analogy in addition to other topics. The term Two-Spirits refers to Native American/Alaska Native Lesbian, Gay, Bisexual, and Transgender (LGBT) individuals. Workshops were offered to increase and encourage awareness, communication, and improve service delivery for LGBTQ individuals of all ages. Presenters shared how to improve coordination of care across systems and increase services and supports. The goal is to learn how to better serve immigrants, refugees, and undocumented clients, along with improving community relations between law enforcement and LGBTQ individuals.

Each year, the latest research and best practices are shared with conference attendees, having one mission in mind, and that is to improve the quality of care, as well as the health and wellbeing of LGBTQ individuals.

## **Behavioral Health Conference**

The Behavioral Health Conference is a three-day statewide behavioral health care conference presented by the Washington Council for Behavioral Health (WCBH) and supported by the federal block. This year's conference theme is "Celebrating Opportunity – Supporting Health and Recovery" was held June 14-16, 2017 in Vancouver Washington.

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

## **Prevention Summit and Youth Forum**

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. The Prevention Summit held in Washington State had the opportunity to work with two other states to host the National Prevention Network (NPN) conference. Youth were encouraged to attend the NPN to create and implement a community project.

The youth were invited back in the spring to present their projects and share their successes at the Spring Youth Forum, which is typically a follow-up conference to the Prevention Summit. This is a peer-to-peer conference for Washington youth teams focused on prevention services where teams can showcase their work and learn from each other.

## Peer Support Training

Washington State's Peer Support Program began in 2005 training mental health individuals with lived experience to become Certified Peer Counselors. Peer support is now provided in every region of the state. 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 underserved populations. In addition to certification training, peer counselor continuing education trainings include Supervision, Ethics, Trauma, Informed Care, and Wellness Recovery Action Plan. As a pilot project, one of the BHOs is working with a few local tribes to implement a behavioral health aide training and certification program. These tribes are requesting that these projects be funded by the federal 1115 Waiver funding and that these services be eligible for Medicaid reimbursement. There will be future discussion between DBHR and the Tribes to include behavioral health aide training within the peer support training track.

In addition to our current adult, youth and family Mental Health Peers, DBHR will be receiving technical assistance through SAMHSA to expand peers to substance abuse disorder treatment as well as piloting SUD peers on homeless outreach teams.

DBHR will also be receiving technical assistance through SAMHSA on workforce development challenges with Substance Abuse Disorder treatment services.

## INNOVATIVE BEHAVIORAL HEALTH STRATEGIES IN WASHINGTON STATE

## Addressing the Opioid Crisis

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

- The Washington State Project to Prevent Prescription Drug/Opioid Overdose (WA-PDO) is a collaborative five-year project between DBHR and the University of Washington Alcohol and Drug Abuse Institute (ADAI) with the purpose of preventing opioid overdose and deaths from opioid overdose, and building local infrastructure to plan, implement, evaluate, and fund overdose prevention efforts in the long-term.
- The Prescription Drug and Opioid Addiction Project (WA-MAT-PDOA) will expand access to
  integrated medication assisted treatment (MAT) with buprenorphine for individuals with an
  opioid addiction. A proven office-based opioid treatment (OBT) model is in both a large urban
  safety-net primary care clinic and two opioid treatment program sites who serve predominately
  rural populations. The WA-MAT-PDOA is a collaborative effort between state agencies,
  Harborview Medical Center, and Evergreen Treatment Services to address the rising rates of
  opioid-related problems in Washington.
- The WA-Opioid STR Project is designed to address the state's opioid epidemic by implementing four major goals: add five new Community Prevention Wellness Initiatives sites; increase prescriber/consumer education, complete an evidenced-based practice analysis, and implement a statewide public education campaign; 2) Treatment/Recovery Support- implement six Hub and Spoke Projects, provide a minimum of five MAT trainings, design/implement a Substance Use Disorder Peers initiative, increase treatment access with financial hardship initiative, reduce correctional recidivism for adults and juveniles, develop a low-barrier Buprenorphine pilot to increase treatment access, engage a minimum of five tribes to design a tribal treatment information campaign and operate Mobile MAT clinics; 3) reduce opioid overdoses by enhancing Naloxone distribution; and 4) enhance the Washington State prescription drug monitoring system.

## Implementation of Secure Withdrawal Management and Stabilization Facilities

The 2015 Legislative Session, House Bill 1713 directed DBHR to create Secure Withdrawal Management and Stabilization Facilities and made changes to multiple aspects of the behavioral health system. Effective April 1, 2018, the bill amends RCW 71.05 and 71.34 to align the substance use involuntary treatment process with the existing mental health ITA process. DBHR will be combining the functions of the Designated Mental Health Professional and the Designated Chemical Dependency Specialist to Designated Crisis Responders who will be authorized to carry out the functions of RCW 71.05 and 71.34. In addition, the bill directs the department to create a sixteen-bed secure detoxification facility to be operational by April 1, 2018. It furthers directs the department to create one additional facility per year until there is a total of nine facilities statewide. These facilities will be licensed as a secure residential treatment facility certified by DBHR to provide withdrawal management and stabilization treatment, under the supervision of physician, for individuals detained under civil involuntary treatment law. These facilities will provide up to 17 days of withdrawal management and stabilizing care to individuals who present a likelihood of serious harm to themselves or others, or are gravely disabled due to a substance use disorder and require withdrawal management treatment. Individuals in need of substance use disorder treatment longer than seventeen days may receive outpatient or residential treatment voluntarily or on a less restrictive alternative.

## **Co-Occurring Disorders**

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

The workgroup set a number of expectations for its work. The group will consider definitions associated with substance use related disorders, mental health disorders, co-occurring disorders, and programs. Key issues include integrated screening, assessment, and treatment planning. Individuals with COD are best served through an integrated screening, assessment, and treatment planning process that addresses both substance use and mental health disorders. Other issues will address appropriate staffing, protocols, methods, and processes for integrated screening, assessment, and treatment planning process that planning for persons with COD as well as systems issues and payment/financing.

The DBHR COD Workgroup will continue to meet during SFY18 and anticipates implementing a statewide COD program by July 1, 2018.

## **Planning Steps**

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

#### Narrative Question:

This step should identify the unmet service needs and critical gaps in the state's current behavioral health system as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state?s behavioral health system. Especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps.

The state's priorities and goals must be supported by a data-driven process. This could include data and information that are available through the state's unique data system (including community-level data), as well as SAMHSA?s data sets including, but not limited to, the <u>National Survey on Drug Use and Health</u> (NSDUH), the <u>Treatment Episode Data Set</u> (TEDS), the <u>National Facilities Surveys on Drug Abuse and</u> <u>Mental Health Services</u>, the annual <u>State and National Behavioral Health Barometers</u>, and the <u>Uniform Reporting System</u> (URS). Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, substance use disorderprevention, and SUD treatment goals at the state level. In addition, states should obtain and include in their data sources information from other state agencies that provide or purchase M/SUD services. This will allow states to have a more comprehensive approach to identifying the number of individuals that are receiving services and the types of services they are receiving.

SAMHSA's Behavioral Health Barometer is intended to provide a snapshot of the state of behavioral health in America. This report presents a set of substance use and mental health indicators measured through two of SAMHSA's populations- and treatment facility-based survey data collection efforts, the NSDUH and the <u>National Survey of Substance Abuse Treatment Services</u> (N-SSATS) and other relevant data sets. Collected and reported annually, these indicators uniquely position SAMHSA to offer both an overview reflecting the behavioral health of the nation at a given point in time, as well as a mechanism for tracking change and trends over time. It is hoped that the National and State specific Behavioral Health Barometers will assist states in developing and implementing their block grant programs.

SAMHSA will provide each state with its state-specific data for several indicators from the <u>Behavioral Health Barometers</u>. States can use this to compare their data to national data and to focus their efforts and resources on the areas where they need to improve. In addition to in-state data, SAMHSA has identified several other data sets that are available to states through various federal agencies: CMS, the Agency for Healthcare Research and Quality (AHRQ), and others.

Through the <u>Healthy People Initiative</u><sup>1</sup> HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

<sup>1</sup> <u>http://www.healthypeople.gov/2020/default.aspx</u>

Footnotes:

## WASHINGTON STATE NEEDS ASSESSMENT

Washington State integrated substance abuse and mental health purchasing in April 2016 and is in the midst of moving to integrated care with primary health by January 2020. Washington currently has one region that has integrated, the second region is expected to be implemented by January 1, 2018. These changes have driven substance use disorder treatment services from a fee-for service program to a managed care model which required changes in how data is being collected. Due to the change, the MHD-CIS and TARGET data systems needed to be replaced by an integrated Behavioral Health Data System (BHDS).

The one caveat to the integration is with the American Indian (AI)/Alaska Native (AN) population, who will have the option of receiving mental health and substance use disorder treatment through the Medicaid managed care system or through a fee-for-service delivery system. The state will continue to maintain the TARGET System for data collection from the fee-for-service system.

The BHDS system has modernized the flow of data, provided increased security, improved accountability, and increased transparency of information, which will assist in refined management decisions and policy development. This system has also strengthened the monitoring and quality of the service delivery system, enhanced outcome analysis for the entire organization, and will further align the organization to a managed care model while maintaining DBHR's ability to track priority outcomes, such as employment and housing for adults with serious mental illness (SMI).

DBHR continues to integrate stakeholder input, including input from the Behavioral Health Advisory Council, as well as the independent peer review summaries to make 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. The SEOW is co-chaired by the DBHR Office Chief for Decision Support and Evaluation and the State Epidemiologist for Non-Infectious Conditions from the Department Health (DOH), and 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 define statewide needs by including representatives from the Northwest Portland Area Indian Health Board Epidemiological Center and the Urban Indian Health Institute as members for the SEOW. During the past year, the SEOW has identified new data sources and provided guidance, as well as data support in identifying the state's prevention priorities through the State Prevention Policy Consortium.

Washington State has implemented major policy changes, such as privatization of spirit sales and legalization of recreational marijuana, so active monitoring of key prevalence indicators and treatment needs is crucial to ensure that our services are adaptable to the changing environment. In the coming year, the SEOW will continue to assess existing data sources, identify data gaps, and develop new data sources. This criteria will be presented to the DBHR Quality Improvement Committee, DBHR Management Team, Behavioral Health Advisory Council, tribes, and stakeholder groups to contribute to these efforts.

## Strategy to Identify Unmet Needs and Gaps

DBHR's planning of prevention and treatment services draws on data from various sources. The biennial statewide **Healthy Youth Survey (HYS)** provides reliable estimates of substance use prevalence and mental health status among in-school adolescents, as well as risk factors that predict poor behavioral health outcomes. The survey, supported by four state agencies and administered every two years in over 80 percent of the state's public schools, is used by DBHR to estimate prevalence rates at state,

county, Behavioral Health Organizations, Accountable Communities of Health, school districts, and even school building levels. The last HYS was conducted in the fall of 2016 which provided data for DBHR's needs assessment, including broadening surveillance capacity for LGBTQ communities, teen anxiety and substance use issues related to vapor products.

For young adults, adults, and older adults, the main data sources for prevalence estimates and epidemiological analyses are **the National Survey on Drug Use and Health (NSDUH)**, the **Behavioral Risk Factor Surveillance System (BRFSS)**, and the **Washington Youth Adult Health Survey (YAHS)**. NSDUH is used to estimate and monitor substance use prevalence rates for various types of substances and BRFSS provides information to identify needs and gaps among various demographic and socioeconomic subpopulations. For example, the Washington BRFSS includes questions that allow us to identify pregnant/parenting women and the LGBTQ subpopulations. However, the small sample size limits the ability to create estimates for these subpopulations without combining multiple years of data, and the minimal number of questions about marijuana and alcohol on these surveys limits the ability to assess how recent policy changes are shaping substance use patterns. DBHR has partnered with researchers at the University of Washington to conduct the YAHS, filling these gaps with a larger sample to allow for comparison of sub-populations, and detailed questions that enable assessment of how substance use patterns are changing among young adults in the state. Moving forward, SEOW will continue to assess data for priority populations and advise on potential data sources to address these gaps.

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

For specific priority subpopulations, including pregnant injecting drug users, pregnant substance abusers, injecting drug users, women with dependent children, and persons at risk for tuberculosis, data will be drawn from other state surveys and administrative databases as well as service data to identify the un-met need. For example, we will use data from the **Pregnancy Risk Assessment Monitoring System (PRAMS)** to estimate the prevalence of substance use among pregnant women and treatment data to identify the rate of treatment for pregnant substance users. When prevalence data is unavailable for certain priority subpopulations, such as women with dependent children, treatment data will be used to monitor rates of admission to SUD treatment. The SEOW will identify data gaps for priority subpopulations and advise on potential data sources.

At the sub-state level, we will use a synthetic process to estimate substance abuse treatment needs. This process combines data from US Census sources for geographic and demographic subgroups to "expand" the NSDUH state-level estimates of AOD treatment need into the desired subgroups (defined by poverty level, age, race/ethnicity, gender).

Detailed community level needs and resources assessments will be used to develop strategic plans to support the individual, community, and local system level. In addition to HYS, the **Community Outcomes and Risk Evaluation (CORE) System** will be used in community level needs assessment. The CORE Geographic Information System (GIS), developed as a set of social indicators highly correlated with adolescent substance use, are kept at the lowest possible level (at least county level, and address level

in some instances). Most indicators originate from the Department of Health, 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

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

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

Using a data-based approach, the Washington State Prevention Enhancement Policy Consortium (SPE) is developing an update to the state's Substance Abuse Prevention and Mental Health Promotion Strategic Plan for the next five-year period. The consortium, comprised of representatives from 25 state and tribal agencies and organizations, conducted an extensive review of state-level data on the use and misuse as well as the impact of alcohol, tobacco, marijuana, prescription drugs, and mental health status. The SEOW provided baseline data and recommendations for indicators to prioritize and will provide updates 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) and through grants awarded to Washington State Community-based organizations (CBOs), were targeted to communities with the highest needs. The SEOW identifies highest-need communities through a risk ranking that integrates data on prevalence of and consequences related to substance use; separate rankings were developed for underage drinking, marijuana use, and all ATOD use. Using the most recent data, SEOW periodically updates the risk rankings. The most recent update was in spring 2017. Because the HYS and CORE data are available at the community and school level, communities and neighborhoods can be identified that otherwise might be overlooked if data were only available at larger geographic units.

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

## **Priorities**

## Priority 1: Reduce Underage and Young Adults Substance Use/Misuse.

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

## Priority 2: Increase the number of youth receiving outpatient substance use disorder treatment Priority 4: Increase the number of adults receiving outpatient substance use disorder treatment

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

## Priority 3: Increase the number of adults with SMI receiving mental health outpatient treatment Priority 8: Increase outpatient mental health services for youth with SED

Mental health treatment services continue to focus on the block grant priority population: youth, adults, and older adults with serious emotional disorder (SED) or serious mental illness (SMI).

## Priority 5: Maintain Government to Government relationships with Tribal Governments

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

**Priority 6:** Increase the number of consumers receiving recovery support services, including increasing employment services and decreasing homelessness for individuals with SMI, SED, and SUD DBHR is committed to decreasing rates of homelessness and increasing rates of employment for adults with behavioral health issues while increasing awareness and using evidence-based practices to address these needs.

## Priority 7: Develop a peer support program for individuals with substance use disorders

DBHR will be piloting a SUD peer pilot project to increase the number of SUD peers working in the field that includes creating a strategic plan to incorporate SUD peer services into the behavioral health system.

The performance indicators identified to track progress in these priority areas are aligned with recent state legislation that drives 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.

HB1519 and SB5732 mandated that the state contract with "service contracting entities" or "service coordination organizations" (i.e., Regional Support Networks, county chemical dependency coordinators, the Area Agencies on Aging, and the managed health care plans) to include specific performance measures to address outcomes in the following areas:

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

The performance indicators used to monitor our progress in our seven priority areas are also aligned with **<u>Results Washington</u>**, which is Washington Governor Jay Inslee's data-driven performance management and continuous improvement system. Within Results Washington, DBHR has the lead responsibility for six success metrics under the Healthy Youth and Adults success indicators. DBHR's Results Washington success metrics include:

- Increase the percentage of mental health consumers receiving a service within 7 days after discharge from inpatient settings from 53.3% (January 2015 average) to 65% by June 2017.
- Contain the percentage of 10th graders who report using marijuana in the past 30 days at 18% from January 2015 to July 2017.
- Decrease the percentage of 10th graders who report drinking alcohol in the past 30 days from 21% in January 2015 to 19% by July 2017.

In addition to the performance indicators above, the state is also tracking MH and SUD service utilization data prior to the implementation of the BHOs and post BHO implementation.

- The target for adults receiving mental services based on RSN utilization trends was set at 50,396. Based on data through January 2017, the state has exceeded this target and has served 54,307 adults.
- The target for children receiving mental services based on RSN utilization trends was set at 19,533. Based on data through January 2017, the state has exceeded this target and has served 21,942 children.
- The target for adults receiving substance use disorder services prior to implementation of the BHOs was 23,868. Based on data through January 2017, the state has not met the target and has served 22,524 adults. However, the state is still resolving issues with completeness of detox and inpatient data after implementation of the BHOs.

• The target for children receiving substance abuse services prior to implementation of the BHOs was set at 1,481. Based on data through January 2017, the state has exceeded this target and has served 1,856 children.

Aligning our Block Grant performance indicators with these efforts allows DBHR to strategically focus on these critical priorities.

# **Planning Steps**

## Quality and Data Collection Readiness

#### Narrative Question:

Health surveillance is critical to SAMHSA's ability to develop new models of care to address substance abuse and mental illness. SAMHSA provides decision makers, researchers and the general public with enhanced information about the extent of substance abuse and mental illness, how systems of care are organized and financed, when and how to seek help, and effective models of care, including the outcomes of treatment engagement and recovery. SAMHSA also provides Congress and the nation reports about the use of block grant and other SAMHSA funding to impact outcomes in critical areas, and is moving toward measures for all programs consistent with SAMHSA's <u>NBHOF</u>. The effort is part of the congressionally mandated National Quality Strategy to assure health care funds – public and private – are used most effectively and efficiently to create better health, better care, and better value. The overarching goals of this effort are to ensure that services are evidence-based and effective or are appropriately tested as promising or emerging best practices; they are person/family-centered; care is coordinated across systems; services promote healthy living; and, they are safe, accessible, and affordable.

SAMHSA is currently working to harmonize data collection efforts across discretionary programs and match relevant NBHQF and National Quality Strategy (NQS) measures that are already endorsed by the National Quality Forum (NQF) wherever possible. SAMHSA is also working to align these measures with other efforts within HHS and relevant health and social programs and to reflect a mix of outcomes, processes, and costs of services. Finally, consistent with the Affordable Care Act and other HHS priorities, these efforts will seek to understand the impact that disparities have on outcomes.

For the FY 2016-2017 Block Grant Application, SAMHSA has begun a transition to a common substance abuse and mental health client-level data (CLD) system. SAMHSA proposes to build upon existing data systems, namely TEDS and the mental health CLD system developed as part of the Uniform Reporting System. The short-term goal is to coordinate these two systems in a way that focuses on essential data elements and minimizes data collection disruptions. The long-term goal is to develop a more efficient and robust program of data collection about behavioral health services that can be used to evaluate the impact of the block grant program on prevention and treatment services performance and to inform behavioral health services research and policy. This will include some level of direct reporting on client-level data from states on unique prevention and treatment services purchased under the MHBG and SABG and how these services contribute to overall outcomes. It should be noted that SAMHSA itself does not intend to collect or maintain any personal identifying information on individuals served with block grant funding.

This effort will also include some facility-level data collection to understand the overall financing and service delivery process on client-level and systems-level outcomes as individuals receiving services become eligible for services that are covered under fee-for-service or capitation systems, which results in encounter reporting. SAMHSA will continue to work with its partners to look at current facility collection efforts and explore innovative strategies, including survey methods, to gather facility and client level data.

The initial draft set of measures developed for the block grant programs can be found at <u>http://www.samhsa.gov/data/quality-metrics/block-grant-measures</u>. These measures are being discussed with states and other stakeholders. To help SAMHSA determine how best to move forward with our partners, each state must identify its current and future capacity to report these measures or measures like them, types of adjustments to current and future state-level data collection efforts necessary to submit the new streamlined performance measures, technical assistance needed to make those adjustments, and perceived or actual barriers to such data collection and reporting.

The key to SAMHSA's success in accomplishing tasks associated with data collection for the block grant will be the collaboration with SAMHSA's centers and offices, the National Association of State Mental Health Program Directors (NASMHPD), the National Association of State Alcohol Drug Abuse Directors (NASADAD), and other state and community partners. SAMHSA recognizes the significant implications of this undertaking for states and for local service providers, and anticipates that the development and implementation process will take several years and will evolve over time.

For the FY 2016-2017 Block Grant Application reporting, achieving these goals will result in a more coordinated behavioral health data collection program that complements other existing systems (e.g., Medicaid administrative and billing data systems; and state mental health and substance abuse data systems), ensures consistency in the use of measures that are aligned across various agencies and reporting systems, and provides a more complete understanding of the delivery of mental health and substance abuse services. Both goals can only be achieved through continuous collaboration with and feedback from SAMHSA's state, provider, and practitioner partners.

SAMHSA anticipates this movement is consistent with the current state authorities' movement toward system integration and will minimize challenges associated with changing operational logistics of data collection and reporting. SAMHSA understands modifications to data collection systems may be necessary to achieve these goals and will work with the states to minimize the impact of these changes.

States must answer the questions below to help assess readiness for CLD collection described above:

- 1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).
- Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).

- 3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-identifying information)?
- 4. If not, what changes will the state need to make to be able to collect and report on these measures?

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

Footnotes:

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 BHA strategic plan and Results Washington, 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 criteria that the QI Committee uses 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 will be 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:

- Individuals 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
- Counties
- BHOs
- Providers

The Quality Management Plan is reviewed and updated annually by the QIC to reflect changing priorities.

# Planning Tables

#### Table 1 Priority Areas and Annual Performance Indicators

| Priority #:    | 1  |
|----------------|--|
| Priority Area: | Reduce Underage and Young Adult Substance Use/Misuse   |
| Priority Type: | SAP  |
| Population(s): | PP, Other (Adolescents w/SA and/or MH, Rural, Asian, Native Hawaiian/Other Pacific Islanders, Underserved Racial and Ethnic<br>Minorities) |

#### Goal of the priority area:

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

#### Objective:

• Decrease the percentage of 10th graders who report using alcohol in the last 30 days (HYS 2016: 20%; Target 2023: 18%).

• Prevent the increase in the percentage of 10th graders who report using marijuana in the last 30 days (HYS 2016: 17%, Target 2023: 15.3%).

• Decrease the percentage of 10th graders who report using tobacco products in the last 30 days (HYS 2016 Tobacco, any form except vape: 10.2%, Target 2023: 9.2%; HYS 2016 Tobacco – vape: 12.7%, Target 2023: 11.4%).

Decrease the percentage of 10th graders who report misusing/abusing painkillers in the past 30 days (HYS 2016: 4.4%, Target 2023: 4.0%).

#### Strategies to attain the objective:

- · Implement performance-based contracting with each prevention contractor.
- Adapt programs to address the unique needs of each tribe.
- Deliver Evidenced-based Prevention Programs and Strategies according to approved strategic plans.
- Deliver direct prevention services.
- Deliver community-based prevention services (Environmental).

Provide statewide Workforce Development Training to build capacity for service delivery.

#### Annual Performance Indicators to measure goal success

| Indicator #:                            | 1  |
|---|--|
| Indicator:                              | Reduce substance use/misuse  |
| Baseline Measurement:                   | 17,302 unduplicated direct services provided   |
| First-year target/outcome measurement:  | Maintain number prevention programs and participants from SFY16 of 17,302 unduplicated direct services               |
| Second-year target/outcome measurement: | Increase service capacity and maintain the number of prevention program delivered to participants receiving services |

#### Data Source:

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

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

Washington State Young Adult Health Survey (YAHS): used to report young adult (Ages 18-25) substance use/misuse.

#### Description of Data:

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

Data issues/caveats that affect outcome measures::

DBHR is implementing a new Management Information System (MIS), the Substance Use Disorder Prevention and Mental Health Promotion MIS. During the time that prevention providers are transitioning to this new system, data quality may be negatively affected as users learn the data entry requirements and as DBHR works with users to identify and correct errors in data entry. Additionally,

outcomes measures may be negatively affected due to data quality concerns and during the process by which DBHR works with its Printed: 8/30/2017 4:04 PM - Washington - OMB No. 0930-0168 Approved: 06/12/2015 Expires: 09/30/2020

# Priority #:2Priority Area:Increase the number of youth receiving outpatient substance use disorder treatmentPriority Type:SATPopulation(s):PWWDC, PWID, Other (Adolescents w/SA and/or MH, LGBTQ, Rural, Criminal/Juvenile Justice, Children/Youth at Risk for BH<br/>Disorder, Homeless, Asian, Native Hawaiian/Other Pacific Islanders, Underserved Racial and Ethnic Minorities)

#### Goal of the priority area:

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

#### Objective:

Require BHOs to maintain behavioral health provider network adequacy.
Increase available SUD outpatient services for youth.

+ ~

#### Strategies to attain the objective:

Explore new mechanism and protocols for case management and continue using Performance Based Contracts to improve access to outpatient services for youth.

| nual Performance Indicators to measu  | re goal success  |
|---|--|
| Indicator #:  | 1  |
| Indicator:  | Increase youth outpatient SUD treatment services   |
| Baseline Measurement:   | Calendar year 2016: 3,588 youth received SUD outpatient treatment services                                       |
| First-year target/outcome measurement:  | Increase the number of youth receiving SUD outpatient treatment services in SFY18 to 3,688                       |
| Second-year target/outcome measurement:   | Increase the number of youth receiving SUD outpatient treatment services in SFY19 to 3,788                       |
| Data Source:  |  |
| The number of youth receiving SUD outpatie<br>Data System (BHDS).                       | ent services is tracked using the Behavioral Health Administration (BHA) Behavioral Health                       |
| Description of Data:  |  |
| The calendar year 2016 data is an unduplica outpatient treatment between January 1, 201 | ted count of youth (persons under 18 years of age) served in publically-funded SUD<br>16, and December 31, 2016. |
| Data issues/caveats that affect outcome mea   | sures::  |
| DBHR combined behavioral health services of   | coverage which has caused data reporting challenges because of the way data was collected                        |

| Priority #:   | 3  |  |
|---|--|--|
| Priority Area:  | Increase the number of adults with SMI receiving mental health outpatient treatment services                           |  |
| Priority Type:  | MHS  |  |
| Population(s):  | SMI, Other (LGBTQ, Homeless, Asian, Native Hawaiian/Other Pacific Islanders, Underserved Racial and Ethnic Minorities) |  |
| Goal of the priority area:  |  |  |
| Increase the number of adults with SMI accessing mental health outpatient services. |  |  |

#### Objective:

• Require BHOs to maintain and enhance behavioral health provider network adequacy.

· Increase available mental health behavioral health services for adults.

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

| ndicator #:   | 1   |
|---|---|
| ndicator:   | Increase mental health outpatient services for adults with SMI  |
| Baseline Measurement:   | Calendar Year 2016: 124,887 adults with SMI received mental health outpatient services  |
| irst-year target/outcome measurement:   | Increase the number of adults with SMI in SFY18 to 125,347  |
| Second-year target/outcome measurement:   | Increase the number of adults with SMI in SFY19 to 125,807  |
| Data Source:  |   |
|   |   |
| Behavioral Health Data System (BHDS).   | l outpatient treatment services is tracked using the Behavioral Health Administration (BHA)   |
| Behavioral Health Data System (BHDS).<br>Description of Data:<br>Calendar year 2016 clients served is an undu | I outpatient treatment services is tracked using the Behavioral Health Administration (BHA)<br>uplicated count of adults with SMI (persons 18 years of age and older) served in publically-<br>between January 1, 2016 and December 31, 2016. |
| Behavioral Health Data System (BHDS).<br>Description of Data:<br>Calendar year 2016 clients served is an undu | uplicated count of adults with SMI (persons 18 years of age and older) served in publically-<br>between January 1, 2016 and December 31, 2016.  |

#### Priority #:

4

| Priority Area: | Increase the number of adults receiving oupatient substance use disorder treatment  |
|----------------|---|
| Priority Type: | SAT   |
| Population(s): | PWWDC, PWID, TB, Other (LGBTQ, Criminal/Juvenile Justice, Homeless, Asian, Native Hawaiian/Other Pacific Islanders, Underserved Racial and Ethnic Minorities) |

Goal of the priority area:

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

Objective:

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

Strategies to attain the objective:

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

| —Annual Performance Indicator | s to measure goal success |  |
|-------------------------------|---------------------------|--|
|                               |                           |  |
| Indicator #:                  | 1                         |  |
|                               |                           |  |

| Indicator:  | Increase outpatient SUD for adults in need of SUD treatment                                |
|---|--|
| Baseline Measurement:   | Calendar Year 2016: 34,889   |
| First-year target/outcome measurement:                              | Increase the number of adults in SFY18 to 35,912   |
| Second-year target/outcome measurement:                             | Increase the number of adults in SFY19 to 36,925   |
| Data Source:  |  |
| The number of adults receiving SUD outpation<br>Data System (BHDS). | ent services is tracked using the Behavioral Health Administration (BHA) Behavioral Health |

Description of Data:

5

In calendar year 2016 is an unduplicated count of adults (persons 18 years of age and older) served in publically-funded SUD outpatient treatment between January 1, 2016 and December 31, 2016.

Data issues/caveats that affect outcome measures::

DBHR combined behavioral health services coverage which has caused data reporting challenges because the way in which data has been collected in the past changed. Indian Health Care Providers have to enter into multiple systems which can be burdensome.

#### Priority #:

| Priority Area: | Maintain Government to Government relationships with Tribal Governments |
|----------------|---|
| Priority Type: | SAP, SAT  |
| Population(s): | PWWDC, PP, PWID, TB, Other (Underserved Racial and Ethnic Minorities)   |

#### Goal of the priority area:

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

#### Objective:

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

within tribal communities.

#### Strategies to attain the objective:

• Each tribe is required complete a Tribal Plan and budget that indicates how the funding will be expended on approved SUD prevention or treatment activities, and DBHR must approve each plan and each update to a Tribal Plan,

• Each tribe must submit quarterly expenditure reports to DBHR.

• Each tribe must input data into each appropriate data system (i.e. TARGET Data System, and Substance Use Disorder (SUD) Prevention and MH Promotion Online Data System) on a quarterly basis.

• DBHR will work in good faith with the Tribes and Urban Indian Health Programs to streamline the data reporting process in the future.

• Each tribe must submit an Annual Narrative Report to reflect on the prevention and treatment services provided with the funding, successes within the program, challenges within the program, etc.

-Annual Performance Indicators to measure goal success Indicator #: 1 Indicator: Maintain treatment and prevention to American Indian/Alaska Natives Baseline Measurement: Prevention 471; Treatment 532 First-year target/outcome measurement: Prevention 471; Treatment 532 Prevention 471; Treatment 532 Second-year target/outcome measurement: Data Source: The Substance Use Disorder Prevention and Mental Health Promotion MIS and TARGET for treatment counts. Description of Data: The number of unduplicated participants in SUD prevention and the total number of clients who received treatment services in SFY2016. Data issues/caveats that affect outcome measures:: Indian Health Care Providers have to enter into multiple systems which is burdensome.

| Priority #:    | 6   |
|----------------|---|
| Priority Area: | Increase the number of consumers receiving recovery support services, including increasing employment services and decreasing homelessness for individuals with SMI, SED, and SUD |
| Priority Type: | SAT, MHS  |
| Population(s): | SMI, SED, PWWDC, PWID, TB, Other (Homeless, Asian, Native Hawaiian/Other Pacific Islanders, Underserved Racial and Ethnic Minorities)   |

Goal of the priority area:

The Washington State Legislature directed Behavioral Health Administration to execute contracts that include performance measures to address shared outcomes in the following areas (SB5732 & HB1519, 2013):

· Improvement in client health status

· Increases in client 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

Measurements for this goal will include employment rate, homelessness rate and stable housing in the community. Number and percent of individuals with any earnings in the quarter of services, homelessness/housing instability using the broad measure of homelessness.

#### Objective:

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

Strategies to attain the objective:

• Train 500 staff (behavioral health, housing and health care) through webinars or in-person training events on evidence-based practice supportive housing and supported employment models

· Assist 300 individuals exiting or at risk of entering inpatient behavioral health settings with housing supports

Assist 300 individuals to obtain employment

Assist 25 behavioral health agencies implement evidence-based practices permanent supportive housing and supported employment models

| nual Performance Indicators to measu          | ire goal success  |
|---|---|
|   | с<br>С  |
| Indicator #:                                  | 1   |
| Indicator:                                    | Increase employment services  |
| Baseline Measurement:                         | 155,411   |
| First-year target/outcome measurement:        | Increase employment by 5% in FY18   |
| Second-year target/outcome measurement:       | Increase employment by 5% in FY19   |
| Data Source:                                  |   |
| Washington State Employment Security Dep      | artment (ESD)   |
| Description of Data:                          |   |
|   | ter in the measurement year with positive earnings recorded in the ESD quarterly wage data.<br>not include self-employment, federal employment, or unreported earnings. |
| Data issues/caveats that affect outcome mea   | isures::  |
| No issues are currently foreseen that will im | pact the outcome of this measure.   |
|   |   |
| Indicator #:                                  | 2   |
| Indicator:                                    | Decrease homelessness   |
| Baseline Measurement:                         | 54,159  |
| First-year target/outcome measurement:        | Decrease by 5%  |
|   |   |

Second-year target/outcome measurement: Decrease by 5%

Data Source:

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

#### Description of Data:

7

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

Data issues/caveats that affect outcome measures::

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

#### Priority #:

| Priority Area: | Develop a peer support program for individuals with substance use disorders  |
|----------------|--|
| Priority Type: | SAT  |
| Population(s): | PWWDC, PWID, TB, Other (Adolescents w/SA and/or MH, Students in College, LGBTQ, Children/Youth at Risk for BH Disorder,<br>Homeless, Asian, Native Hawaiian/Other Pacific Islanders, Underserved Racial and Ethnic Minorities) |

Goal of the priority area:

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

#### Objective:

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

#### Strategies to attain the objective:

• BHA/DBHR will seek input from key stakeholders and certified peers to guide the development of a strategic plan incorporating peer services within the substance use treatment service delivery system

- · Identify any curriculum adjustments needed to integrate SUD peer services
- Strategic planning to incorporate SUD peer services into the system of care, exploring funding strategies and rule changes

## Annual Performance Indicators to measure goal success

| 1  |  |  |  |  |
|--|--|--|--|--|
| SUD peer support program   |  |  |  |  |
| Currently, Washington does not have SUD peers  |  |  |  |  |
| Develop a peer support program in SFY18 that would include 20 peers                              |  |  |  |  |
| Increase the number of SUD peers in in SFY19 to 28 peers   |  |  |  |  |
|  |  |  |  |  |
| Monthly reports submitted to DBHR through the STR Peer Pathfinder project                        |  |  |  |  |
| Description of Data:   |  |  |  |  |
| Excel reports indicating the number of individuals served by SUD Peers on the Pathfinder project |  |  |  |  |
| Data issues/caveats that affect outcome measures::   |  |  |  |  |
| No issues are currently foreseen that will affect the outcome measures.                          |  |  |  |  |
|  |  |  |  |  |

Priority #:

Priority Area:

8

Increase outpatient mental health services for youth with SED

Priority Type: MHS

Population(s): SED

Goal of the priority area:

The Division of Behavioral Health and Recovery (DBHR) uses MHBG funds to provide behavioral health services, including services not covered by Medicaid to Medicaid individuals and low income individuals, not eligible for other forms of funding (e.g. Medicaid). The primary goal is to increase community based behavioral health services to youth who are diagnosed with SED.

#### Objective:

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

#### Strategies to attain the objective:

• Require BHOs to maintain behavioral health provider network adequacy.

Increase available MH community based behavioral health services for youth diagnosed with SED.

| Indicator #: 1   |  |  |  |
|--|--|--|--|
| Indicator:   | Increase oupatient MH services to youth with SED   |  |  |
| Baseline Measurement:  | Calendar year 2016: 50,451 youth with SED received services  |  |  |
| First-year target/outcome measurement:   | Increase the number of youth with SED receiving outpatient services to 51,000                                      |  |  |
| Second-year target/outcome measurement:  | Increase the number of youth with SED receiving outpatient services 51,450   |  |  |
| Data Source:   |  |  |  |
|  |  |  |  |
| The number of youth with SED receiving MH<br>Health Data System (BHDS).                          | outpatient services is reported in the Behavioral Health Administration (BHA) Behavioral                           |  |  |
| Health Data System (BHDS).   | outpatient services is reported in the Behavioral Health Administration (BHA) Behavioral                           |  |  |
| Health Data System (BHDS).<br>Description of Data:   | t of youth with SED who under the age of 18 served in publically funded outpatient mental                          |  |  |
| Health Data System (BHDS).<br>Description of Data:<br>Calendar year 2016 is an unduplicated coun | t of youth with SED who under the age of 18 served in publically funded outpatient mental<br>gh December 31, 2016. |  |  |

Footnotes:

# Planning Tables

## Table 2 State Agency Planned Expenditures [SA]

#### Planning Period Start Date: 7/1/2017 Planning Period End Date: 6/30/2019

| Activity<br>(See instructions for using Row<br>1.)  | A.Substance<br>Abuse Block<br>Grant | B.Mental<br>Health Block<br>Grant | C.Medicaid<br>(Federal,<br>State, and<br>Local) | D.Other<br>Federal<br>Funds (e.g.,<br>ACF (TANF),<br>CDC, CMS<br>(Medicare)<br>SAMHSA,<br>etc.) | E.State<br>Funds | F.Local<br>Funds<br>(excluding<br>local<br>Medicaid) | G.Other |
|---|-------------------------------------|-----------------------------------|---|---|------------------|--|---------|
| 1. Substance Abuse Prevention and Treatment   | \$52,797,658                        |                                   | \$500,000,006                                   | \$30,988,000  | \$124,318,000    | \$18,757,000   | \$0     |
| a. Pregnant Women and<br>Women with Dependent<br>Children   | \$3,771,261                         |                                   | \$13,331,276                                    | \$0   | \$3,000,000      | \$0  | \$0     |
| b. All Other  | \$49,026,397                        |                                   | \$486,668,730                                   | \$30,988,000  | \$121,318,000    | \$18,757,000   | \$0     |
| 2. Primary Prevention   | \$18,856,307                        |                                   | \$0   | \$0   | \$0              | \$0  | \$0     |
| a. Substance Abuse Primary<br>Prevention  | \$18,856,307                        |                                   | \$0   | \$0   | \$0              | \$0  | \$0     |
| b. Mental Health Primary  |                                     |                                   |   |   |                  |  |         |
| 3. Evidence-Based Practices for<br>Early Serious Mental Illness (10<br>percent of total award MHBG) |                                     |                                   |   |   |                  |  |         |
| 4. Tuberculosis Services  | \$0                                 |                                   | \$0   | \$0   | \$0              | \$0  | \$0     |
| 5. Early Intervention Services for<br>HIV   | \$0                                 |                                   | \$0   | \$0   | \$0              | \$0  | \$0     |
| 6. State Hospital   |                                     |                                   |   |   |                  |  |         |
| 7. Other 24 Hour Care   |                                     |                                   |   |   |                  |  |         |
| 8. Ambulatory/Community Non-<br>24 Hour Care  |                                     |                                   |   |   |                  |  |         |
| 9. Administration (Excluding<br>Program and Provider Level)   | \$3,771,261                         |                                   | \$0   | \$0   | \$7,500,000      | \$1,454,000  | \$0     |
| 10. SubTotal (1,2,3,4,9)  | \$56,568,919                        | \$0                               | \$500,000,006                                   | \$30,988,000  | \$131,818,000    | \$20,211,000   | \$0     |
| 11. SubTotal (5,6,7,8)  | \$0                                 | \$0                               | \$0   | \$0   | \$0              | \$0  | \$0     |
| 12. Total   | \$75,425,226                        | \$0                               | \$500,000,006                                   | \$30,988,000  | \$131,818,000    | \$20,211,000   | \$0     |

\* Prevention other than primary prevention

\*\* The 20 percent set-aside funds in the SABG must be used for activities designed to prevent substance misuse.

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## Footnotes:

# Planning Tables

## Table 2 State Agency Planned Expenditures [MH]

#### Planning Period Start Date: 7/1/2017 Planning Period End Date: 6/30/2019

| Activity<br>(See instructions for using Row<br>1.)  | A.Substance<br>Abuse Block<br>Grant | B.Mental<br>Health Block<br>Grant | C.Medicaid<br>(Federal,<br>State, and<br>Local) | D.Other<br>Federal<br>Funds (e.g.,<br>ACF (TANF),<br>CDC, CMS<br>(Medicare)<br>SAMHSA,<br>etc.) | E.State<br>Funds | F.Local<br>Funds<br>(excluding<br>local<br>Medicaid) | G.Other |
|---|-------------------------------------|-----------------------------------|---|---|------------------|--|---------|
| 1. Substance Abuse Prevention<br>and Treatment  |                                     |                                   |   |   |                  |  |         |
| a. Pregnant Women and<br>Women with Dependent<br>Children   |                                     |                                   |   |   |                  |  |         |
| b. All Other  |                                     |                                   |   |   |                  |  |         |
| 2. Primary Prevention   |                                     | \$0                               | \$0   | \$0   | \$0              | \$0  | \$0     |
| a. Substance Abuse Primary<br>Prevention  |                                     |                                   |   |   |                  |  |         |
| b. Mental Health Primary  |                                     |                                   | \$0   | \$0   | \$0              | \$0  | \$0     |
| 3. Evidence-Based Practices for<br>Early Serious Mental Illness (10<br>percent of total award MHBG) <sup>**</sup> |                                     | \$1,873,580                       | \$0   | \$0   | \$0              | \$0  | \$0     |
| 4. Tuberculosis Services  |                                     |                                   |   |   |                  |  |         |
| 5. Early Intervention Services for<br>HIV   |                                     |                                   |   |   |                  |  |         |
| 6. State Hospital   |                                     |                                   | \$296,186,000                                   | \$0   | \$416,666,000    | \$52,630,000   | \$0     |
| 7. Other 24 Hour Care   |                                     | \$0                               | \$0   | \$0   | \$15,862,000     | \$0  | \$0     |
| 8. Ambulatory/Community Non-<br>24 Hour Care  |                                     | \$15,925,430                      | \$1,610,152,750                                 | \$36,776,200  | \$191,647,250    | \$0  | \$0     |
| 9. Administration (Excluding<br>Program and Provider Level)   |                                     | \$936,790                         | \$20,522,000                                    | \$0   | \$12,444,000     | \$502,000  | \$0     |
| 10. SubTotal (1,2,3,4,9)  | \$0                                 | \$936,790                         | \$20,522,000                                    | \$0   | \$12,444,000     | \$502,000  | \$0     |
| 11. SubTotal (5,6,7,8)  | \$0                                 | \$17,799,010                      | \$1,906,338,750                                 | \$36,776,200  | \$624,175,250    | \$52,630,000   | \$0     |
| 12. Total   | \$0                                 | \$18,735,800                      | \$1,926,860,750                                 | \$36,776,200  | \$636,619,250    | \$53,132,000   | \$0     |

\* While the state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMH or children with SED

\*\* Column 9B should include Early Serious Mental Illness programs funded through MHBG set aside

### Footnotes:

# **Planning Tables**

Table 3 SABG Persons in need/receipt of SUD treatment

|                                       | Aggregate Number Estimated In Need | Aggregate Number In Treatment |
|---------------------------------------|------------------------------------|-------------------------------|
| Pregnant Women                        | 0                                  | 788                           |
| Women with Dependent Children         | 0                                  | 1783                          |
| Individuals with a co-occurring M/SUD | 0                                  | 23025                         |
| Persons who inject drugs              | 0                                  | 14313                         |
| Persons experiencing homelessness     | 0                                  | 17183                         |

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

The state does not have a way of estimating the need for treatment.

Footnotes:

# **Planning Tables**

# Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

| Expenditure Category                                    | FFY 2018 SA Block Grant Award |
|---|-------------------------------|
| 1. Substance Abuse Prevention and Treatment             | \$26,398,829                  |
| 2. Primary Substance Abuse Prevention                   | \$9,428,153                   |
| 3 . Early Intervention Services for ${\sf HIV}^{\star}$ |                               |
| 4. Tuberculosis Services                                |                               |
| 5 . Administration (SSA Level Only)                     | \$1,885,631                   |
| 6. Total  | \$37,712,613                  |

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

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# Planning Tables

# Table 5a SABG Primary Prevention Planned Expenditures

# Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

| Strategy                            | IOM Target  | FY 2018              |
|-------------------------------------|-------------|----------------------|
|                                     |             | SA Block Grant Award |
|                                     | Universal   |                      |
|                                     | Selective   |                      |
| Information Dissemination           | Indicated   |                      |
|                                     | Unspecified | \$307,711            |
|                                     | Total       | \$307,711            |
|                                     | Universal   |                      |
|                                     | Selective   |                      |
| Education                           | Indicated   |                      |
|                                     | Unspecified | \$1,524,694          |
|                                     | Total       | \$1,524,694          |
|                                     | Universal   |                      |
|                                     | Selective   |                      |
| Alternatives                        | Indicated   |                      |
|                                     | Unspecified | \$322,413            |
|                                     | Total       | \$322,413            |
|                                     | Universal   |                      |
|                                     | Selective   |                      |
| Problem Identification and Referral | Indicated   |                      |
|                                     | Unspecified | \$3,123,817          |
|                                     | Total       | \$3,123,817          |

| 1  |             |              |
|--|-------------|--------------|
|  | Universal   |              |
|  | Selective   |              |
| Community-Based Process                  | Indicated   |              |
|  | Unspecified | \$3,450,528  |
|  | Total       | \$3,450,528  |
|  | Universal   |              |
|  | Selective   |              |
| Environmental                            | Indicated   |              |
|  | Unspecified | \$85,570     |
|  | Total       | \$85,570     |
|  | Universal   |              |
|  | Selective   |              |
| Section 1926 Tobacco                     | Indicated   |              |
|  | Unspecified |              |
|  | Total       | \$0          |
|  | Universal   |              |
|  | Selective   |              |
| Other                                    | Indicated   |              |
|  | Unspecified | \$613,420    |
|  | Total       | \$613,420    |
| Total Prevention Expenditures            |             | \$9,428,153  |
| Total SABG Award*                        |             | \$37,712,613 |
| Planned Primary Prevention<br>Percentage |             | 25.00 %      |

\*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

# Planning Tables

# Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

| Activity                              | FY 2018 SA Block Grant Award |
|---------------------------------------|------------------------------|
| Universal Direct                      |                              |
| Universal Indirect                    |                              |
| Selective                             |                              |
| Indicated                             |                              |
| Column Total                          | \$0                          |
| Total SABG Award*                     | \$37,712,613                 |
| Planned Primary Prevention Percentage | 0.00 %                       |

\*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

# Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

| Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019 |   |
|---|---|
| Targeted Substances   |   |
| Alcohol   | Ð |
| Tobacco   | Ð |
| Marijuana   | Ð |
| Prescription Drugs  | Ð |
| Cocaine   | ê |
| Heroin  | Ð |
| Inhalants   | ê |
| Methamphetamine   | ê |
| Synthetic Drugs (i.e. Bath salts, Spice, K2)                              | þ |
| Targeted Populations  |   |
| Students in College   | Ø |
| Military Families   | þ |
| LGBT  | Ð |
| American Indians/Alaska Natives   | Ð |
| African American  | Ð |
| Hispanic  | Ð |
| Homeless  | b |
| Native Hawaiian/Other Pacific Islanders                                   | Ð |
| Asian   | Ð |
| Rural   | Ð |
| Underserved Racial and Ethnic Minorities                                  | Ð |

# **Planning Tables**

# Table 6 Categories for Expenditures for System Development/Non-Direct-Service Activities

# Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

| Activity  | A. MHBG   | B. SABG<br>Treatment | C. SABG<br>Prevention | D. SABG<br>Combined* |
|---|-----------|----------------------|-----------------------|----------------------|
| 1. Information Systems  | \$200,000 | \$119,363            | \$175,814             |                      |
| 2. Infrastructure Support                                     | \$69,000  |                      | \$246,000             |                      |
| 3. Partnerships, community outreach, and needs assessment     |           |                      |                       |                      |
| 4. Planning Council Activities (MHBG required, SABG optional) | \$30,000  | \$503,978            |                       |                      |
| 5. Quality Assurance and Improvement                          | \$62,485  | \$358,089            |                       |                      |
| 6. Research and Evaluation                                    | \$178,000 | \$92,838             | \$29,926              |                      |
| 7. Training and Education                                     | \$306,196 | \$153,030            | <b>\$</b> 18,704      |                      |
| 8. Total  | \$845,681 | \$1,227,298          | \$470,444             | \$0                  |

\*Combined refers to non-direct service/system development expenditures that support both treatment and prevention systems.

### 1. The Health Care System, Parity and Integration - Question 1 and 2 are Required

#### Narrative Question

1. The Health Care System, Parity and Integration

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.<sup>25</sup> Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but "[h]ealth system factors" such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.<sup>26</sup> It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.<sup>27</sup>

Currently, 50 states have organizationally consolidated their mental and substance use disorder authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.<sup>28</sup> SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.<sup>29</sup> For instance, some organizations have established medical-legal partnerships to assist persons with mental and substance use disorders in meeting their housing, employment, and education needs.<sup>30</sup>

Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and behavioral health with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.<sup>31</sup> SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.<sup>32</sup> The state should illustrate movement towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders. The plan should describe attention to management, funding, payment strategies that foster co-occurring capability for services to individuals and families with co-occurring mental and substance use disorders. Strategies supported by SAMHSA to foster integration of physical and behavioral health include: developing models for inclusion of behavioral health treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between M/SUD providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as Federally Qualified Health Centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including EHRs and telehealth are examples of important strategies to promote integrated care.<sup>33</sup> Use of EHRs - in full compliance with applicable legal requirements ? may allow providers to share information, coordinate care, and improve billing practices. Telehealth is another important tool that may allow behavioral health prevention, treatment, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time, and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes<sup>34</sup> and ACOs<sup>35</sup> may be important strategies used by SMHAs and SSAs to foster integrated care.

Training and assisting behavioral health providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes. SMHAs and SSAs also may work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations.<sup>36</sup> Ensuring both Medicaid and private insures provide required preventive benefits also may be an area for collaboration.<sup>37</sup>

One key population of concern is persons who are dually eligible for Medicare and Medicaid.<sup>38</sup> Roughly, 30 percent of persons who are dually eligible have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.<sup>39</sup> SMHAs and SSAs also should collaborate with state Medicaid agencies and state insurance commissioners to develop policies to assist those individuals who Printed: 8/30/2017 4:04 PM - Washington - OMB No. 0930-0168 Approved: 06/12/2015 Expires: 09/30/2020 Page

experience health insurance coverage eligibility changes due to shifts in income and employment.<sup>40</sup> Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with behavioral health conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider.<sup>41</sup> SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of behavioral health conditions and work with partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.

SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.<sup>42</sup> Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists, and others will need to understand integrated care models, concepts, and practices.

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

SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues. Another key part of integration will be defining performance and outcome measures. The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, which includes information and resources to help promote health, good outcomes, and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.<sup>43</sup> SAMHSA recognizes that certain jurisdictions receiving block grant funds ? including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Medicaid provisions or are ineligible to participate in certain programs.<sup>44</sup> However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment, and recovery support for persons with, or at risk of, mental and substance use disorders.

<sup>27</sup> Comorbidity: Addiction and other mental illnesses, http://www.drugabuse.gov/publications/comorbidity-addiction-other-mental-illnesses/why-do-drug-use-disordersoften-co-occur-other-mental-illnesses Hartz et al., Comorbidity of Severe Psychotic Disorders With Measures of Substance Use, JAMA Psychiatry. 2014; 71(3):248-254. doi:10.1001/jamapsychiatry.2013.3726; http://www.samhsa.gov/co-occurring/

<sup>28</sup> Social Determinants of Health, Healthy People 2020, http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39; http://www.cdc.gov/socialdeterminants/Index.html

<sup>29</sup> http://www.samhsa.gov/health-disparities/strategic-initiatives

<sup>30</sup> http://medical-legalpartnership.org/mlp-response/how-civil-legal-aid-helps-health-care-address-sdoh/

<sup>31</sup> Integrating Mental Health and Pediatric Primary Care, A Family Guide, 2011. http://www.nami.org/Content/ContentGroups/CAAC/FG-Integrating.pdf; Integration of Mental Health, Addictions and Primary Care, Policy Brief, 2011,

http://www.nami.org/Content/NavigationMenu/State\_Advocacy/About\_the\_Issue/Integration\_MH\_And\_Primary\_Care\_2011.pdf; Abrams, Michael T. (2012, August 30). Coordination of care for persons with substance use disorders under the Affordable Care Act: Opportunities and Challenges. Baltimore, MD: The Hilltop Institute, UMBC. http://www.hilltopinstitute.org/publications/CoordinationOfCareForPersonsWithSUDSUnderTheACA-August2012.pdf; Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes, American Hospital Association, Jan. 2012, http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf; American Psychiatric Association, http://www.psych.org/practice/professional-interests/integrated-care; Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series ( 2006), Institute of Medicine, National Affordable Care Academy of Sciences, http://books.nap.edu/openbook.php? record\_id=11470&page=210; State Substance Abuse Agency and Substance Abuse Program Efforts Towards Healthcare Integration: An Environmental Scan, National Association of State Alcohol/Drug Abuse Directors, 2011, http://nasadad.org/nasadad-reports

<sup>32</sup> Health Care Integration, http:// samhsa.gov/health-reform/health-care-integration; SAMHSA-HRSA Center for Integrated Health Solutions,

(http://www.integration.samhsa.gov/)

<sup>&</sup>lt;sup>25</sup> BG Druss et al. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Med Care. 2011 Jun; 49(6):599-604; Bradley Mathers, Mortality among people who inject drugs: a systematic review and meta-analysis, Bulletin of the World Health Organization, 2013; 91:102?123 http://www.who.int/bulletin/volumes/91/2/12-108282.pdf; MD Hert et al., Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care, World Psychiatry. Feb 2011; 10(1): 52?77

<sup>&</sup>lt;sup>26</sup> Research Review of Health Promotion Programs for People with SMI, 2012, http://www.integration.samhsa.gov/health-wellness/wellness

<sup>33</sup> Health Information Technology (HIT), http://www.integration.samhsa.gov/operations-administration/hit; Characteristics of State Mental Health Agency Data Systems, SAMHSA, 2009, http://store.samhsa.gov/product/Characteristics-of-State-Mental-Health-Agency-Data-Systems/SMA08-4361; Telebehavioral Health and Technical Assistance Series, http://www.integration.samhsa.gov/operations-administration/telebehavioral-health; State Medicaid Best Practice, Telemental and Behavioral Health, August 2013, American Telemedicine Association, http://www.americantelemed.org/docs/default-source/policy/ata-best-practice--telemental-and-behavioral-health.pdf?sfvrsn=8; National Telehealth Policy Resource Center, http://telehealthpolicy.us/medicaid; telemedicine, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Telemedicine.html

<sup>34</sup> Health Homes, http://www.integration.samhsa.gov/integrated-care-models/health-homes

<sup>35</sup> New financing models, http://www.samhsa.gov/co-occurring/topics/primary-care/financing\_final.aspx

<sup>36</sup> Waivers, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html; Coverage and Service Design Opportunities for Individuals with Mental Illness and Substance Use Disorders, CMS Informational Bulletin, Dec. 2012, http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-12-03-12.pdf

<sup>37</sup> What are my preventive care benefits? https://www.healthcare.gov/what-are-my-preventive-care-benefits/; Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 75 FR 41726 (July 19, 2010); Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 76 FR 46621 (Aug. 3, 2011); Preventive services covered under the Affordable Care Act, http://www.hhs.gov/healthcare/facts/facts/heets/2010/07/preventive-services-list.html

38 Medicare-Medicaid Enrollee State Profiles, http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/StateProfiles.html; About the Compact of Free Association, http://uscompact.org/about/cofa.php

<sup>39</sup> Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies, CBO, June 2013, http://www.cbo.gov/publication/44308

40 BD Sommers et al. Medicaid and Marketplace Eligibility Changes Will Occur Often in All States; Policy Options can Ease Impact. Health Affairs. 2014; 33(4): 700-707

<sup>41</sup> TF Bishop. Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care, JAMA Psychiatry. 2014;71(2):176-181; JR Cummings et al, Race/Ethnicity and Geographic Access to Medicaid Substance Use Disorder Treatment Facilities in the United States, JAMA Psychiatry. 2014; 71(2):190-196; JR Cummings et al. Geography and the Medicaid Mental Health Care Infrastructure: Implications for Health Reform. JAMA Psychiatry. 2013; 70(10):1084-1090; JW Boyd et al. The Crisis in Mental Health Care: A Preliminary Study of Access to Psychiatric Care in Boston. Annals of Emergency Medicine. 2011; 58(2): 218

42 Hoge, M.A., Stuart, G.W., Morris, J., Flaherty, M.T., Paris, M. & Goplerud E. Mental health and addiction workforce development: Federal leadership is needed to address the growing crisis. Health Affairs, 2013; 32 (11): 2005-2012; SAMHSA Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues, January 2013, http://store.samhsa.gov/shin/content/PEP13-RTC-BHWORK/PEP13-RTC-BHWORK.pdf; Annapolis Coalition, An Action Plan for Behavioral Health Workforce Development, 2007, http://annapoliscoalition.org/?portfolio=publications; Creating jobs by addressing primary care workforce needs, http://www.hhs.gov/healthcare/facts/factsheets/2013/06/jobs06212012.html

<sup>43</sup> About the National Quality Strategy, http://www.ahrq.gov/workingforquality/about.htm; National Behavioral Health Quality Framework, Draft, August 2013, http://samhsa.gov/data/NBHQF

<sup>44</sup> Letter to Governors on Information for Territories Regarding the Affordable Care Act, December 2012, http://www.cms.gov/cciio/resources/letters/index.html; Affordable Care Act, Indian Health Service, http://www.ihs.gov/ACA/

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

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

Washington's Medicaid system is in the process of transitioning from two distinct managed care systems to a 'whole person' system of care whereby the full continuum of physical and behavioral health care is managed through health plan managed care contracts. These contracts integrate the financing of physical and behavioral health care and include value-based payment to drive innovation and clinical integration at the practice level. One of nine regional service areas (RSAs) implemented fully integrated managed care (FIMC) in April 2016. A second region will implement FIMC in January 2018, with the remaining regions following suit by 2020.

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

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

The National Survey on Drug Use and Health (NSDUH) 2010/2011 data reports that 75 percent of individuals in Washington State with mental health or substance use disorder conditions also have chronic medical conditions. Fully integrated managed care implemented across the state will position Washington State to provide whole-person care along a continuum of need.

As a result of integrating the behavioral health delivery system, the state fully integrated the managed care payments that were provided for mental health services and the fee-for-service payments provided for substance use disorder services into a behavioral health managed care rate. This provides the flexibility for the BHOs to provide services across the continuum of substance use and mental health disorders and removes a funding silo. The state is currently reviewing, state rules and laws, contract language, state plan authority and funding strategies to support more models of co-occurring services. This work is being done in partnership with the BHOs, MCOs, providers and other stakeholders with the goal to provide as much clarity and flexibility within our current laws, funding, and state plan to support co-occurring delivery models.

| 3. |   | e a plan<br>h QHPs | for monitoring whether individuals and families have access to M/SUD services offered<br>?   | ja Yes ja No |
|----|---|--------------------|--|--------------|
|    | and M   | edicaid?           |  | ja Yes ja No |
| 4. | Who is  | respon             | sible for monitoring access to M/SUD services by the QHP?  |              |
| 5. | Is the S  | SSA/SMI            | A involved in any coordinated care initiatives in the state?   | jm Yes jm No |
| 6. | Do the  | behavio            | oral health providers screen and refer for:  |              |
|    | a)  | Preven             | tion and wellness education  | jm Yes jm No |
|    | b)  | Health             | risks such as  |              |
|    |   | i)                 | heart disease  | ja Yes ja No |
|    |   | ii)                | hypertension   | jn Yes jn No |
|    |   | viii)              | high cholesterol   | ja Yes ja No |
|    |   | ix)                | diabetes   | jm Yes jm No |
|    | c)  | Recove             | ry supports  | jm Yes jm No |
| 7. |   |                    | A involved in the development of alternative payment methodologies, including risk-based ationships that advance coordination of care? | jn Yes jn No |
| 8. |   |                    | SMHA involved in the implementation and enforcement of parity protections for mental and disorder services?                            | jn Yes jn No |
| 9. | What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions? |                    |  |              |

9. What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions?

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

Please indicate areas of technical assistance needed related to this section

## 2. Health Disparities - Requested

#### Narrative Question

In accordance with the HHS Action Plan to Reduce Racial and Ethnic Health Disparities<sup>45</sup>, Healthy People, 2020<sup>46</sup>, National Stakeholder Strategy for Achieving Health Equity<sup>47</sup>, and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and behavioral health outcomes among individuals of all cultures, sexual/gender minorities, orientation and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS)<sup>48</sup>.

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the HHS Secretary released in April 2011, outlines goals and actions that HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to assess the impact of their policies and programs on health disparities.

The HHS Secretary's top priority in the Action Plan is to "assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."49

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status<sup>50</sup>. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations<sup>51</sup>. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBT populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide behavioral health services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

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

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

- <sup>45</sup> http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS Plan complete.pdf
- <sup>46</sup> <u>http://www.healthypeople.gov/2020/default.aspx</u>

- <sup>50</sup> http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=208

<sup>&</sup>lt;sup>47</sup> <u>http://minorityhealth.hhs.gov/npa/files/Plans/NSS/NSSExecSum.pdf</u>

<sup>48</sup> http://www.thinkculturalhealth.hhs.gov

<sup>49</sup> http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS\_Plan\_complete.pdf

## Please respond to the following items:

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

| a) Race  | jm Yes jm No |
|--|--------------|
| b) Ethnicity   | ja Yes ja No |
| c) Gender  | ja Yes ja No |
| d) Sexual orientation  | ja Yes ja No |
| e) Gender identity   | ja Yes ja No |
| f) Age   | ja Yes ja No |
| Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population?   | ja Yes ja No |
| Does the state have a plan to identify, address and monitor linguistic disparities/language barriers?  | ja Yes ja No |
| Does the state have a workforce-training plan to build the capacity of behavioral health providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations? | jn Yes jn No |
| If yes, does this plan include the Culturally and Linguistically Appropriate Services(CLAS) standard?  | ja Yes ja No |
| Does the state have a budget item allocated to identifying and remedialing disparities in behavioral health care?  | ja Yes ja No |
| Does the state have any activities related to this section that you would like to highlight?   |              |
| Please indicate areas of technical assistance needed related to this section   |              |

Footnotes:

2.

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4.

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7.

### 3. Innovation in Purchasing Decisions - Requested

#### Narrative Question

While there are different ways to define value-based purchasing, the purpose is to identify services, payment arrangements, incentives, and players that can be included in directed strategies using purchasing practices that are aimed at improving the value of health care services. In short, health care value is a function of both cost and quality:

Health Care Value = Quality ? Cost, (V = Q ? C)

SAMHSA anticipates that the movement toward value based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of behavioral health systems and services.

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including M/SUD services. Over the past several years, SAMHSA has collaborated with CMS, HRSA, SMAs, state behavioral health authorities, legislators, and others regarding the evidence of various mental and substance misuse prevention, treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states' use of the block grants for this purpose. The NQF and the IOM recommend that evidence play a critical role in designing health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. NREPP assesses the research evaluating an intervention's impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. NREPP ratings take into account the methodological rigor of evaluation studies, the size of a program's impact on an outcome, the degree to which a program was implemented as designed, and the strength of a program's conceptual framework. For each intervention reviewed, NREPP publishes a report called a program profile on this website. You will find research on the effectiveness of programs as reviewed and rated by NREPP certified reviewers. Each profile contains easily understandable ratings for individual outcomes based on solid evidence that indicates whether a program achieved its goals. NREPP is not intended to be an exhaustive listing of all evidence-based practices in existence.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with SED. The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General<sup>52</sup>, The New Freedom Commission on Mental Health<sup>53</sup>, the IOM<sup>54</sup>, and the NQF<sup>55</sup>. The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."<sup>56</sup> SAMHSA and other federal partners, the HHS' Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the behavioral health field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocol Series (TIPS)<sup>57</sup> are best practice guidelines for the SUD treatment. The CSAT draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation (KIT)<sup>58</sup> was developed to help move the latest information available on effective behavioral health practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement behavioral health practices that work. KIT, part of SAMHSA's priority initiative on Behavioral Health Workforce in Primary and Specialty Care Settings, covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and Printed: 8/30/2017 4:04 PM - Washington - OMB No. 0930-0168 Approved: 06/12/2015 Expires: 09/30/2020 Page training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers' decisions regarding M/SUD services.

<sup>56</sup> <u>http://psychiatryonline.org/</u>

#### Please respond to the following items:

| 1. | Is information used regarding evidence-based or promising practices in your purchasing or policy | jn Yes in No |  |
|----|--|--------------|--|
|    | decisions?   |              |  |

- 2. Which value based purchasing strategies do you use in your state (check all that apply):
  - a) Eadership support, including investment of human and financial resources.
  - b) E Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
  - c) 🗧 Use of financial and non-financial incentives for providers or consumers.
  - d) e Provider involvement in planning value-based purchasing.
  - e) E Use of accurate and reliable measures of quality in payment arrangements.
  - f) E Quality measures focus on consumer outcomes rather than care processes.
  - g) E Involvement in CMS or commercial insurance value based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P)).
  - h) E The state has an evaluation plan to assess the impact of its purchasing decisions.

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

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

<sup>&</sup>lt;sup>52</sup> United States Public Health Service Office of the Surgeon General (1999). Mental Health: A Report of the Surgeon General. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

<sup>&</sup>lt;sup>53</sup> The President's New Freedom Commission on Mental Health (July 2003). Achieving the Promise: Transforming Mental Health Care in America. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

<sup>&</sup>lt;sup>54</sup> Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders (2006). Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. Washington, DC: National Academies Press.

<sup>&</sup>lt;sup>55</sup> National Quality Forum (2007). National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices. Washington, DC: National Quality Forum.

<sup>&</sup>lt;sup>57</sup> <u>http://store.samhsa.gov</u>

<sup>&</sup>lt;sup>58</sup> <u>http://store.samhsa.gov/shin/content//SMA08-4367/HowtoUseEBPKITS-ITC.pdf</u>

4. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) - 10 percent set aside - Required MHBG

### Narrative Question

Much of the mental health treatment and recovery are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among consumers and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention\* is critical to treating mental illness before it can cause tragic results like serious impairment, unemployment, homelessness, poverty, and suicide. The duration of untreated mental illness, defined as the time interval between the onset of a mental disorder and when an individual gets into treatment, has been a predictor of outcome across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be viewed as a negative prognostic factor for those who are diagnosed with mental illness. Earlier treatment and interventions not only reduce acute symptoms, but may also improve long-term prognosis.

States may implement models that have demonstrated efficacy, including the range of services and principles identified by National Institute of Mental Health (NIMH) via its Recovery After an Initial Schizophrenia Episode (RAISE) initiative. Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, states should move their system to address the needs of individuals with a first episode of psychosis (FEP). NIMH sponsored a set of studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP the RAISE model). The NIMH RAISE studies, as well as similar early intervention programs tested worldwide, consist of multiple evidence-based treatment components used in tandem as part of a CSC model, and have been shown to improve symptoms, reduce relapse, and improved outcomes.

State shall expend not less than 10 percent of the amount the State receives for carrying out this section for each fiscal year to support evidencebased programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset. In lieu of expending 10 percent of the amount the State receives under this section for a fiscal year as required a state may elect to expend not less than 20 percent of such amount by the end of such succeeding fiscal year.

\* MHBG funds cannot be used for primary prevention activities. States cannot use MHBG funds for prodromal symptoms (specific group of symptoms that may precede the onset and diagnosis of a mental illness) and/or those who are not diagnosed with a SMI.

### Please respond to the following items:

1

2

| 1. | Does the state have policies for addressing early serious mental illness (ESMI)?   | jn Yes jn No |
|----|--|--------------|
| 2. | Has the state implemented any evidence based practices (EBPs) for those with ESMI? | jn Yes jn No |

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

The Mental Health Block Grant (MHBG) 10 percent set aside currently supports three Coordinated Specialty Care (CSC) teams, including the New Journeys Demonstration Project at Central Washington Comprehensive Mental Health in Yakima, which began in 2015. The set aside supported the start-up of two additional sites in Thurston-Mason and King Counties. The state is also working to expand to two additional sites in the Greater Columbia and Great Rivers area. All Demonstration Project sites receive training, technical assistance and consultation from a team of local and national experts led by Dr. Maria Monroe-DeVita from the University of Washington (UW) Department of Psychiatry and Behavioral Sciences. Dr. Monroe-DeVita is the project director and oversees all aspects of implementation, including program start up, training, ongoing consultation, and coordination and planning between the Demonstration Projects and DBHR. Dr. Monroe-DeVita is joined by her training team at UW, along with national experts from the NAVIGATE program to ensure proper training and fidelity to New Journeys.

Teams, utilizing New Journeys CSC model, are comprised of four to six clinicians with the appropriate expertise. Key roles, in addition to outreach and engagement, include team leadership, case management, supported employment and education, psychotherapy and skills training, family education and support, pharmacotherapy, 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.

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

The state partnered with the Washington Council for Behavioral Health (WCBH) in May 2016 to begin the groundwork to make Printed: 8/30/2017 4:04 PM - Washington - OMB No. 0930-0168 Approved: 06/12/2015 Expires: 09/30/2020

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

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- Does the state coordinate across public and private sector entities to coordinate treatment and recovery j∩ Yes j∩ No supports for those with a ESMI?
- 5. Does the state collect data specifically related to ESMI?
- 6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI?
- 7. Please provide an updated description of the state's chosen EBPs for the 10 percent set-aside for ESMI.

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8. Please describe the planned activities for FFY 2018 and FFY 2019 for your state's ESMI programs including psychosis?

The planned activities for FFY2018 and 2019 are:

• Development of New Journeys Network, overseeing the implementation and training of two additional Coordinated Specialty Care Demonstration Sites.

Implementation of NAVIGATE Coordinated Specialty Care Training and Consultation

All New Journeys Demonstration Projects will implement NAVIGATE as their Coordinated Specialty Care model. Sites are required to attend and participate in all trainings, and participate in bi-weekly consultation calls. In addition to participation in training and consultation, all sites will be encouraged to engage in peer-to-peer learning opportunities throughout the project.

• Evaluation and data collection by Dr. Michael McDonell from the Elson S. Floyd College of Medicine at Washington State University to oversee the evaluation of the New Journeys Network. The evaluation includes use of the EBP Toolkit, a secure online database that clinicians will use to document outreach activities, referral information, as well as information about consumer demographics and mental health history. Clinicians will also use the EBP Toolkit to enter and monitor clinical outcomes data in order to better target treatment interventions. All Demonstration Project sites will be required to enter evaluation and clinical monitoring data into the EBP Toolkit throughout the course of implementation.

• A partnership with Pat Deegan and Associates to provide resources and education to provider agencies to improve knowledge of recovery principles and provide access to resources for both individuals and clinicians to prepare them for meaningful engagement in their treatment. Pat Deegan and Associates will provide access to the Common Ground Academy and access to the Recovery Library for the two new demonstration sites as well as current New Journeys Providers. The course includes participation in the "Hearing Voices" simulation, recovery, engagement, and the process of client-driven, person-centered treatment for both the provider and client. The Recovery Library provides access to tools for recovery for individuals in recovery, family members, providers, and supporters.

The objectives of the New Journeys Network are to:

• Reduce the duration of untreated psychosis through early and appropriate detection and response, thereby potentially reducing the severity of the illness.

in Yes in No

• Minimize the disruption in the lives of adolescents and young adults who experience psychosis so they can reintegrate and maintain educational, vocational, social, and other roles.

• Minimize the societal impact of psychosis including reducing demand in other areas of the mental health and the health and social service systems and reducing disruption in the lives of families.

Use the gathered data for quality improvement in existing programs and to improve the implementation of future sites.
Increase capacity of current service providers.

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

There are two prongs of data collection. The first is with the Washington State Department of Social and Health Services (DSHS), Research and Data Analysis (RDA) Division, which collects and summarizes data on DSHS clients who have experienced psychotic episodes. They provide descriptive data on demographics, behavioral health characteristics, family history (when available), services that have been required from state systems, arrests and involvement with juvenile justice system, and trajectories from the first encounter with psychosis. RDA is using this data to operationalize a definition of First Episode Psychosis through administrative data.

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

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

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

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

Age Range: 15-25 with exceptions made up to 40 years old, based on clinical judgment and the New Journey's Model

Diagnoses: Schizophrenia, Schizoaffective Disorder, Schizophrenia form Disorder, Brief Psychotic Disorder, or Psychotic Disorder not otherwise specified

Duration of Illness/Symptoms: >1 week and < years AND/OR < six months of lifetime treatment with antipsychotic medications. Only one episode of psychosis (i.e., individuals with a psychotic episode followed by full system remission and relapse to another psychotic episode are excluded)

IQ: Over 70

Diagnostic Exclusions: Symptoms not know to be caused by a medical condition or drug use Austism Does the state have any activities related to this section that you would like to highlight?

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

### 5. Person Centered Planning (PCP) - Required MHBG

#### Narrative Question

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers where appropriate in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning is a process through which individuals develop their plan of service. The PCP may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP may include family members, legal guardians, friends, caregivers and others that the person or his/her representative wishes to include. The PCP should involve the person receiving services and supports to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person's strengths, goals, preferences, needs and desired outcome. The role of state and agency workers (for example, options counselors, support brokers, social workers, peer support workers, and others) in the PCP process is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs and provide support during planning. The person's goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, family relationships, and treatments are part of a written plan that is consistent with the person's needs and desires.

- 1. Does your state have policies related to person centered planning? i∩ Yes in No
- 2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.
- 3. Describe how the state engages consumers and their caregivers in making health care decisions, and enhance communication.

Both the Program of Assertive Community Treatment (PACT) and the Wraparound with Intensive Services (WISe) models define a specific process for treatment planning that are very inclusive of the individuals and their family or others identified by the individual as part of their treatment team. These are person-centered explorations of strengths and challenges across multiple life domains. Fidelity monitoring specifically looks for inclusion of natural supports and PACT fidelity monitoring ensures that all members of PACT teams receive person centered planning training.

In addition to those individuals receiving PACT and WISe services, all individuals receiving outpatient mental health services are engaged in the development of an individualized service plan. Washington Administrative Code 388-877A-0135 directs outpatient mental health providers to develop individualized treatment plans that are "consumer-driven, strengths-based, and meet the individual's unique mental health needs". Further, these plans must identify at least one goal identified by the individual or their parent or legal representative and identify services mutually agreed upon by the individual and provider. Washington State promotes the use of Mental Health Advance Directives, a method by which an individual can communicate their decisions about mental health treatment in advance of times when they are incapacitated.

4. Describe the person-centered planning process in your state.

Individuals receiving their mental health treatment under the authorization of the regional Behavioral Health Organizations participate in a collaborative treatment planning process. This process draws upon the needs identified across life domains during the assessment, as well as their strengths and challenges. Treatment is individualized and determined in partnership with the individual as well as those natural supports that the individual chooses to include in their care planning. Treatment plans often include client quotations that document their goals. These treatment plans are living documents that are revisited over the course of treatment and adapted based upon client needs and preferences. Programs such as WISe and PACT stress an even greater emphasis on person centered planning, as described above.

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

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

### 6. Self-Direction - Requested

#### Narrative Question

In self-direction - also known as self-directed care - a service user or "participant" controls a flexible budget, purchasing goods and services to achieve personal recovery goals developed through a person-centered planning process. While this is not an allowable use of Block Grant Funds, the practice has shown to provide flexible supports for an individual's service. The self-direction budget may comprise the service dollars that would have been used to reimburse an individual's traditional mental health care, or it may be a smaller fixed amount that supplements a mental health benefit. In self-direction, the participant allocates the budget in a manner of his or her choosing within program guidelines. The participant is encouraged to think creatively about setting goals and is given a significant amount of freedom to work toward those goals. Purchases can range from computers and bicycles to dental care and outpatient mental health treatment.

Typically, a specially trained coach or broker supports the participant to identify resources, chart progress, and think creatively about the planning and budgeting processes. Often a peer specialist who has received additional training in self-direction performs the broker role. The broker or a separate agency assists the participant with financial management details such as budget tracking, holding and disbursing funds, and hiring and payroll logistics. Self-direction arrangements take different forms throughout the United States and are housed and administered in a variety of entities, including county and state behavioral health authorities, managed care companies, social service agencies, and advocacy organizations.

Self-direction is based on the premise that people with disabilities can and should make their own decisions about the supports and services they receive. Hallmarks of self-direction include voluntary participation, individual articulation of preferences and choices, and participant responsibility. In recent years, physical and mental health service systems have placed increasing emphasis on person-centered approaches to service delivery and organization. In this context, self-direction has emerged as a promising practice to support recovery and well-being for persons with mental health conditions. A small but growing evidence base has documented self-direction's impact on quality of life, community tenure, and psychological well-being.

#### Please respond to the following items:

| 1. | Does y  | your state have policies related to self-direction?   | ja Yes ja No |
|----|---------|---|--------------|
| 2. | Are the | jn Yes jn No  |              |
|    | If yes, |   |              |
|    | a)      |   |              |
|    | b)      | What are the eligibility criteria?  |              |
|    | c)      | How are budgets set, and what is the scope of the budget?   |              |
|    | d)      | What role, if any, do peers with lived experience of the mental health system play in the initiative?     |              |
|    | e)      | What, if any, research and evaluation activities are connected to the initiative?                         |              |
|    | f)      | If no, describe any action steps planned by the state in developing self-direction initiatives in the fur | ture.        |
|    | Does t  | he state have any activities related to this section that you would like to highlight?                    |              |
|    | Please  | indicate areas of technical assistance needed to this section.  |              |

# 7. Program Integrity - Required

#### Narrative Question

SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds. While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for behavioral health services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x-5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x-55(g), SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: http://www.samhsa.gov/sites/default/files/grants/guidance -for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SABG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance use disorder prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the MHBG and SABG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered M/SUD benefits; (3) ensuring that consumers of M/SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of behavioral health benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

#### Please respond to the following items:

- 1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements jn Yes jn No are conveyed to intermediaries and providers?
- 2. Does the state provide technical assistance to providers in adopting practices that promote compliance  $j \cap Yes j \cap No$  with programs requirements, including quality and safety standard?

Does the state have any activites related to this section that you would like to highlight?

DBHR program managers work with their contractors to review claims, identify overpayments, and educate providers and others on block grant program integrity issues.

DBHR also provides support and assistance to the Behavioral Health Organizations (BHO) and Tribes in their efforts to combat fraud and abuse as well as to promote best practices in an effort to raise awareness of fraud, waste, and abuse.

Contract requirements are passed down to subcontractors, which are reviewed and discussed prior to the subcontracts being sent out to providers. Contract managers conduct reviews at least once per year or once per biennium. Additional reviews may be done if there are challenges with providers or providers request technical assistance. In addition to contract monitoring, the Behavioral Health Administration, Division of Budget and Finance conducts an annual review of the BHOs' financial information. Part of the fiscal monitoring is to ensure that block grant funds are being used appropriately. If deficiencies are found, a corrective action plan is initiated and reviews occur more frequently.

#### On a monthly basis:

• Budget and Finance Division in conjunction with DBHR leadership conducts monthly reviews of the block grant budgets.

• Claim and payment adjustments are done as needed to ensure block grant expenditures are being properly recorded for allowable block grant services.

• Expenditure reports are reviewed monthly and invoices are reviewed and approved by the contract manager prior to the payment being issued.

• Client level encounter, utilization, and performance analysis are completed as part of the invoice approval process and contract/fiscal monitoring process.

Please indicate areas of technical assistance needed to this section

### 8. Tribes - Requested

#### Narrative Question

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the 2009 Memorandum on Tribal Consultation<sup>59</sup> to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that approximately 70 percent of American Indians and Alaska Natives do not live on tribal lands. The SMHAs, SSAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the states.

States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

<sup>59</sup> http://www.whitehouse.gov/the-press-office/memorandum-tribal-consultation-signed-president

### Please respond to the following items:

- 1. How many consultation sessions has the state conducted with federally recognized tribes?
  - A summary of recent collaboration between DBHR and the Tribes are as follows:

• 2000 to current: The DSHS Office of Indian Policy created Contract Consolidation as a means to simplify annual reporting for Tribes that receive funding from DSHS Administrations. All 29 Tribes currently receive block grant funding to provide prevention (SABG only) and treatment services to their community members who are not Medicaid-eligible.

• 2013 to current: Ongoing monthly meetings between DBHR, HCA, and Tribal representatives to discuss the transition of behavioral health services from the fee-for-service system to the managed care system as a result of 2013 Senate Bill 5732, and 2013 Senate Bill 6312.

• August 2015: DSHS and Tribes formally consulted on the SAMHSA Combined Block Grant for tribal input.

• October 2015: DSHS, HCA, and Tribes formally consulted on exempting Medicaid-eligible AI/ANs from SUD managed care services and remaining in the FFS system.

- July 2016: DSHS and Tribes formally consulted on the SAMHSA Combined Block Grant Biennial Plan for tribal input.

• October 2016: DSHS, HCA, and Tribes formally consulted on exempting Medicaid-eligible AI/ANs from the MH managed care system and commit to establishing the MH FFS system.

- June 13, 2017: DSHS and Tribes conducted the first roundtable discussion with the Tribes to review the FFY2018-19
- June 26, 2017: DSHS and Tribes conducted the second roundtable discussion with Tribes.
- July 14, 2017: DSHS and Tribes formally consulted on the SAMHSA Combined Block Grant Biennial Plan for tribal input.
- July 1, 2017: DBHR implemented the MH FFS system for Medicaid-eligible AI/AN individuals.

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

1) Have DBHR remind the BHOs that FFS AI/AN can choose to opt into managed care.

2) Wanted specific narrative to be changed for the tribal section. More specifically, adding in contracting opportunities for Tribes,

clarity Medicaid AI/AN can opt into managed care, and clarification regarding coordination of crisis services between the BHOs

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#### and Tribes.

3) Burdensome reporting requirements for the Tribes because they have enter data into multiple data system.

Does the state have any activites related to this section that you would like to highlight?

The Department of Social and Health Services has adopted a government-to-government policy called Administrative Policy 7.01. This policy defines the consultation, collaboration, and communication protocols when policy, funding, services, and other changes affect American Indians (AI) and Alaska Natives (AN). The Department is committed to the establishment of intergovernmental relationships with the Federally Recognized Tribes of Washington State and the development and delivery of beneficial services to AI/AN families and individuals in need. DBHR recognizes the importance of collaborating with Tribes, Urban Indian Health Programs (UIHPs) as designated Indian Health Care Providers under the Indian Health Care Improvement Act (IHCIA), and Recognized American Indian Organizations (RAIOs), including Urban Indian Health Programs across the state to ensure that AI/ANs have access to behavioral health services that are culturally sensitive and appropriate.

In 2013, the Tribal Centric Behavioral Health (TCBH) Workgroup submitted a report to the Legislature describing a TCBH System and identifying the characteristics that exemplify a TCBH System. The workgroup's recent focus (between the years 2013-2016) was on the implementation of Washington State Substitute Senate Bill 6312. This bill directed the Department to integrate the publicly funded substance use disorder (SUD) program and mental health (MH) program, and transition SUD treatment into a managed care environment through new entities called Behavioral Health Organizations (BHOs) by April 1, 2016. Following formal consultations with the Tribes, it was decided to exempt the Medicaid-eligible Al/AN population from the managed care system for both SUD and MH services. As a result, SUD and MH outpatient and residential services were placed into a fee-for-service (FFS) delivery system for Medicaid-eligible Al/AN individuals. Additionally, tribal providers were able to directly refer their Medicaideligible Al/AN clients to non-tribal SUD and MH outpatient and inpatient providers within a FFS system. It is important to note that Al/AN individuals covered by Medicaid can choose to opt into the managed care system and receive SUD and MH services through the BHO system of providers; Al/AN individuals can also access care directly from an Indian Health Care Provider regardless of whether the provider is contracted with a BHO. While Al/AN individuals have the option to choose Medicaid behavioral health care coverage under either managed care or the FFS system, it does not impact the block grant funding that Tribes currently receive. DBHR is committed to continue providing SABG funds to the Tribes.

Please indicate areas of technical assistance needed to this section

## 9. Primary Prevention - Required SABG

## Narrative Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

- Information Dissemination providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
- Education aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
- Alternative programs that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
- *Problem Identification* and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
- Community-based Process that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
- Environmental Strategies that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

### Please respond to the following items

### Assessment

- 1. Does your state have an active State Epidemiological and Outcomes Workgroup(SEOW)? j∩ Yes j∩ No
- 2. Does your state collect the following types of data as part of its primary prevention needs assessment j∩ Yes j∩ No process? (check all that apply)
  - Data on consequences of substance using behaviors
  - **b** Substance-using behaviors
  - 6 Intervening variables (including risk and protective factors)
  - Others (please list)

Local contributing factors

- 3. Does your state collect needs assessment data that include analysis of primary prevention needs for the following population groups? (check all that apply)
  - 6 Children (under age 12)
  - Youth (ages 12-17)
  - Young adults/college age (ages 18-26)
  - Adults (ages 27-54)
  - Older adults (age 55 and above)
  - 6 Cultural/ethnic minorities
  - Sexual/gender minorities
  - 6 Rural communities

#### Others (please list)

- 4. Does your state use data from the following sources in its Primary prevention needs assessment? (check all that apply)
  - Archival indicators (Please list)
  - a. Washington Department of Health and DSHS Research and Data Analysis:
  - i. Alcohol related injury/accident (hospitalization)
  - ii. Other drugs related injury/accident (hospitalization)
  - iii. Tobacco-related deaths
  - iv. Alcohol-related deaths
  - v. Other drug deaths Drug-related deaths
  - vi. Opioid-related deaths All Opioids, Prescriptions, Heroin
  - € National survey on Drug Use and Health (NSDUH)
  - e Behavioral Risk Factor Surveillance System (BRFSS)
  - Youth Risk Behavioral Surveillance System (YRBS)
  - € Monitoring the Future
  - Communities that Care
  - State developed survey instrument
  - Others (please list)

b. Uniform Crime Reporting:

- i. Arrests Alcohol Violation
- ii. Arrests Alcohol-related
- iii. Arrests Drug Violation
- iv. Arrests Drug-related
- c. Office of Superintendent of Public Instruction:
- i. High School Extended Graduation Rate (includes on-time graduation)
- d. Comprehensive Hospital Abstract Reporting System (CHARS):
- i. Suicide and attempts
- e. Washington Department of Transportation and Washington State Highway Safety Commission
- i. Fatalities and Serious Injury from Crashes:
- Alcohol-Related Traffic Injuries and Alcohol-Related Traffic Fatalities.
- f. Washington Healthy Youth Survey:
- i. Underage Drinking (10th Grade)
- ii. Marijuana Misuse/Abuse (10th Grade)
- iii. Prescription Misuse/Abuse (10th Grade)
- iv. Pain Killer User (10th Grade)
- v. Tobacco Misuse/Abuse (10th Grade)
- vi. E-Cigarette/Vapor Products Misuse/Abuse (10th Grade)
- vii. Poly substance Misuse/Abuse (10th Grade)
- viii. Sad/Hopeless in Past 12 Months (10th Grade)
- ix. Suicide Ideation (10th Grade)
- x. Suicide Plan (10th Grade)
- xi. Suicide Attempt (10th Grade)
- xii. Bullied/Harassed/Intimidated (10th Grade)
- xiii. Source of Alcohol, Pain Killers Used to Get High; Marijuana; Vapor Products (10th Grade)
- xiv. Perception of Availability of Alcohol, Marijuana, Cigarettes; Opioids (10th Grade)
- xv. Risk Perception of Alcohol, Marijuana (10th Grade)
- xvi. Knowledge of Laws, Perception of Enforcement Alcohol, Marijuana (10th Grade)
- g. Washington Young Adult Health Survey:
- i. Young Adult (18-25) Marijuana Misuse/Abuse
- ii. Alcohol Use
- iii. Source of Marijuana
- h. Pregnancy Risk Assessment Monitoring System (PRAMS):
- i. Pregnant Women Report Alcohol Use Any Time During Pregnancy
- i. Washington State Liquor and Cannabis Control Board:
- i. Count of State Liquor Licenses
- ii. Count of State Marijuana Store Licenses and Processor Licenses
- 5. Does your state use needs assessment data to make decisions about the allocation SABG primary prevention funds?

jn Yes in No

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

If no, (please explain) how SABG funds are allocated:

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

Please indicate areas of technical assistance needed related to this section

#### Narratve Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

- Information Dissemination providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
- Education aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
- Alternative programs that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
- Problem Identification and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
- Community-based Process that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
- Environmental Strategies that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

# **Capacity Building**

1. Does your state have a statewide licensing or certification program for the substance use disorder  $j \cap Yes j \cap No$  prevention workforce?

If yes, please describe

Through the Prevention Specialist Certification Board of Washington, the state provides a Certified Prevention Professional (CPP) credential. DBHR supports individuals in obtaining their CPP by providing sessions of the Washington Substance Abuse Prevention Skills Training (SAPST) via contract with the Prevention Certification Board. Starting with the 2015-2017 contracts, DBHR contractually requires credentialing of community coalition coordinators.

2. Does your state have a formal mechanism to provide training and technical assistance to the substance use jn Yes jn No disorder prevention workforce?

#### If yes, please describe mechanism used

DBHR provides training and technical assistance for communities and prevention providers as they implement prevention services. There are currently two DBHR staff with significant assignments that include workforce development and implementing the Training Plan. The Training Plan covers the entire calendar year and includes the following components which provide a number of recurring workforce and capacity development opportunities in a variety of formats:

• Annual Training: DBHR hosts two statewide conferences for prevention professional and community partner capacity building and youth prevention team capacity building.

o These conferences provide educational and culturally competent training and networking opportunities for individuals and groups active in the field of prevention, including youth, volunteers, and prevention professionals. DBHR prevention staff participate both as presenters and attendees.

o In calendar year 2016, training topics included Creating LGBTQ Inclusive Environments to better understand how to reduce health disparities and Sharing your Personal Brand with the Media to better understand how to use media in prevention work.
Monthly Training: DBHR hosts on-going, optional monthly training sessions during the third hour of the on-line monthly CPWI

Learning Community Meetings attended by sub recipients.

o Webinar training topics in calendar year 2016 included:

Reducing Health Disparities

Prevention Advocacy

**Counterproductive Prevention Strategies** 

Science of Positive Social Norms

Administering the Community Survey

Prescription Drug Misuse/Abuse Prevention.

• Webinar Series: DBHR hosts a number of on-line trainings. Calendar year 2016 topics are representative of these continuing

education opportunities:

o The Strategic Prevention Framework Webinar Series, covering organization and governance, needs assessment, planning, implementation, and evaluation.

- o Evidence-based Program Trainings to provide training on specific prevention programs.
- DBHR Technical Assistance Training and On-going Support:
- o DBHR provides regular and timely Technical Assistance to CPWI communities covering:
- ? The Substance User Disorder Prevention and Mental Health Promotion Online Management Information System (MIS)
- ? Strategic plan development
- ? Action plan updates
- ? SPF implementation
- ? Contract compliance

3.

o In addition to live technical assistance, DBHR provides access to all training materials, shared documents, calendar of events, and other resources on our workforce development and capacity development website, www.theAthenaForum.org.

Does your state have a formal mechanism to assess community readiness to implement prevention  $j_{ij}$  Yes  $j_{ij}$  No strategies?

#### If yes, please describe mechanism used

Washington has a formal mechanism to assess community readiness in collaboration with Washington counties, Educational Service Districts (ESDs), and communities. DBHR joins with key partners and stakeholders to work with the highest need communities to follow a selection process that identifies if the communities are at a high enough level of readiness. This readiness is assessed by the community support for developing and implementing the CPWI. The readiness 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 their agreement to join the coalition. Additionally, school district support was assessed and documented to leverage funding to support the required match costs for the Prevention/Intervention Specialist in the middle and or high school in the community. If a community was determined to not have enough readiness, the next highest need community was assessed for readiness.

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

Please indicate areas of technical assistance needed related to this section

#### Narratve Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

- Information Dissemination providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
- Education aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
- Alternative programs that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
- Problem Identification and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
- Community-based Process that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
- Environmental Strategies that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

## Planning

- 1. Does your state have a strategic plan that addresses substance use disorder prevention that was  $j \cap Yes \ j \cap No$  developed within the last five years?
  - If yes, please attach the plan in BGAS by going to the <u>Attachments Page</u> and upload the plan

The current State of Washington Substance Abuse and Mental Health Promotion Five-Year Strategic Plan was developed in 2012 and updated in 2015 (link to plan). The state is currently in the process of updating the plan with the most recent data available. The update to the Plan is projected to be completed in fall 2017.

- 2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of j∩ Yes j∩ N/A the SABG? (N/A no prevention strategic plan)
- 3. Does your state's prevention strategic plan include the following components? (check all that apply):
  - a) Based on needs assessment datasets the priorities that guide the allocation of SABG primary prevention funds
  - b) 😝 Timelines
  - c) **b** Roles and responsibilities
  - d) b Process indicators
  - e) 6 Outcome indicators
  - f) 6 Cultural competence component
  - g) 🗗 Sustainability component
  - h) b Other (please list):
    - 1. Resource assessment

i)

- 2. Prevention research theories
- Not applicable/no prevention strategic plan
- 4. Does your state have an Advisory Council that provides input into decisions about the use of SABG primary j∩ Yes j∩ No prevention funds?
- 5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate j∩ Yes j∩ No strategies to be implemented with SABG primary prevention funds?

If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based

The State's Evidence-based Workgroup determines evidence-based practices and strategies. Membership includes representatives from the prevention research subcommittee, the Washington State Institute for Public Policy (WSIPP), and academic partners. The Workgroup focuses on building and maintaining up-to-date lists of evidence-based programs and practices. Additionally, DBHR has 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. This list is the evidence-based program and practice list that our sub-recipients for primary prevention services are permitted to select from. To determine whether a strategy is evidence-based, the Workgroup consults the National Registry for Evidence-based Programs and Practices (NREPP), Blueprints for Healthy Youth Development, a separate list of programs identified as evidence-based by the State of Oregon, and the "Scientific Evidence for Developing a Logic Model on Underage Drinking: A Reference Guide for Community Environmental Prevention" report.

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

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

#### Narratve Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

## Implementation

- 1. States distribute SABG primary prevention funds in a variety of different ways. Please check all that apply to your state:
  - SSA staff directly implements primary prevention programs and strategies. a) Ð b) Ð The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract). c) The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts. ê d) The SSA funds regional entities that provide training and technical assistance. ê The SSA funds regional entities to provide prevention services. e) Ð f) The SSA funds county, city, or tribal governments to provide prevention services. Ð The SSA funds community coalitions to provide prevention services. g) Ð h) The SSA funds individual programs that are not part of a larger community effort. ê i) The SSA directly funds other state agency prevention programs. ê
  - j) e Other (please describe)
- 2. Please list the specific primary prevention programs, practices, and strategies that are funded with SABG primary prevention dollars in each of the six prevention strategies. Please see the introduction above for definitions of the six strategies:
  - a) Information Dissemination:

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

b) Education:

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

c) Alternatives:

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

d) Problem Identification and Referral:

SABG will be funded via a contract with the Office of Superintendent of Public Instruction (OSPI) to implement "Project SUCCESS" and sustain full time prevention/intervention staff in each CPWI community's school district.

#### e) Community-Based Processes:

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

f) Environmental:

SABG funds support communities to implement strategies that address community identified priorities to impact community-level change. Strategies focus on community norms, policies, and attitudes that impact availability, access, and enforcement to prevent youth substance use.

3. Does your state have a process in place to ensure that SABG dollars are used only to fund primary  $j \cap Yes j \cap No$  prevention services not funded through other means?

#### If yes, please describe

In addition to the SABG, the State of Washington provides only a small amount of funds for prevention, which does not meet the state's prevention needs. To ensure compliance, DBHR's Prevention System Managers (PSMs) monitor expenditures to ensure that SABG dollars are used as required by the grant. DBHR's contracts specify approved uses of these funds and PSMs engage in routine monitoring activities to ensure alignment with these requirements.

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

CSAP Category Program Name Alternatives Across Ages Alternatives Big Brothers Big Sisters Mentoring Program Community-based Processes Communities That Care (CTC) Community-based Processes Gathering of Native Americans Community-based Processes PROSPER Education Alcohol Literacy Challenge (ALC) **Education All Stars** Education Al's Pals: Kids Making Healthy Choices Education Athletes Training & Learning to Avoid Steroids Education ATLAS (Athletes Training and Learning to Avoid Steroids) Education Brief Alcohol Screening and Intervention for College Students (BASICS) Education Brief Strategic Family Therapy Education Child Development Project Education Children In Between **Education Class Action Education Coping Power** Education Coping with Work and Family Stress Education Creating Lasting Family Connections (CLFC) Education Curriculum Based Support Group Program (CBSG) Education DARE to Be You (DTBY) Education Early Risers--Skills for Success **Education Familias Unidas** Education Families and Schools Together (FAST) Education Family Effectiveness Training (FET) **Education Family Matters Education Family Spirit Education Friendly PEERsuasion** Education Good Behavior Game Education Guiding Good Choices Education Healer Women Fighting Disease Integrated Substance Abuse and HIV Prevention for African American Women (HWFD) Education Healing of the Canoe Education Healthy Alternatives for Little Ones (HALO) Education Healthy Living Project for People Living with HIV Education Healthy Workplace Education Hip-Hop 2 Prevent Substance Abuse and HIV (H2P) Education Home-Based Behavioral Systems Family Therapy Education I Can Problem Solve (ICPS) Education I'm Special **Education Incredible Years** Education Keep A Clear Mind Education Keepin' it REAL

Education LifeSkills Training Program (LST) Education Lions Quest Skills for Adolescence Education Media Detective Education Media Ready Education Native American Prevention Project Against AIDS and Substance Abuse (NAPPASA) Education Not On Tobacco (NOT) Education Nurse Family Partnership **Education Nurturing Parenting Programs Education Parent Management Training Education Parenting Wisely Education Parents as Teachers Education Peacemakers** Education Peer Assistance and Leadership (PAL) **Education Positive Action Education Positive Indian Parenting** Education PRIME for Life Education Project ALERT **Education Project EX Education Project Northland** Education Project Towards No Drug Abuse Education Project Towards No Tobacco Use **Education Project Venture** Education Promoting Alternative Thinking Strategies (PATHS), PATHS Preschool Education Protecting You/Protecting Me Education Raising Healthy Children (using SSDP model) Education Reconnecting Youth: A Peer Group Approach to Building Life Skills Education Red Cliff Wellness School Curriculum Education Residential Student Assistance Program (RSAP) Education Say it Straight Education Schools and Families Educating Children (SAFEChildren) **Education Second Step** Education Sembrando Salud **Education SMART Leaders** Education Social Competence Promotion Program for Young Adolescents (SCPP-YA) **Education SPORT Education STARS for Families** Education State-wide Indian Drug Prevention Education Stay on Track Education Storytelling for Empowerment **Education Strengthening Families Program** Education Strengthening Families Program: for Parents and Youth 10-14 Education Strengthening Multi-Ethnic Families and Communities Education Strong African American Families **Education Team Awareness** Education Too Good for Drugs Education Wellness Outreach at Work **Environmental Advertising Restrictions** Environmental Blood Alcohol Concentration Laws (Per se Laws) Environmental Border-Binge Drinking Reduction Program Environmental Challenging College Alcohol Abuse Environmental Changing Hours and Days of Sale Environmental Communities Mobilizing for Change on Alcohol (CMCA) Environmental Community Trials Intervention to Reduce High-Risk Drinking Environmental Community Trials Intervention to Reduce High-Risk Drinking (adapted for marijuana) **Environmental Compliance Checks** Environmental Densities or Concentration of Retail Outlets- Changing Conditions of Availability Environmental Drinking Locations and Possession of Alcohol--Changing Conditions of Availability Environmental Drug Impairment Training for Educational Professionals (DITEP) Environmental Economic Interventions (Increasing Taxes) **Environmental Interlock Devices** Environmental Keg Registration-Changing Conditions of Availability Environmental License Suspension/Revocation Environmental Lower Levels of Alcohol in Beverages **Environmental Party Intervention Patrols Environmental Policy Review and Development** 

Environmental Project ACHIEVE Environmental Project STAR/Midwestern Prevention Project Environmental Purchase Surveys coupled with Reward and Reminder Environmental Raising the Minimum Drinking Age Environmental Responsible Beverage Service Environmental Restricting Access to Alcohol at Social Events--Changing Conditions of Availability Environmental Restrictions at Community Events Environmental Restrictions on Price Promotions and Alcohol Discounts--Changing Conditions of Availability Environmental Reward and Reminder **Environmental School Policies Environmental Sobriety Checkpoints** Environmental Social Host Ordinance Environmental Social Norms Marketing Environmental Source Investigation Training (Reducing Social and Third Party Access) Environmental State Retail Monopolies Environmental Tobacco-Free Environmental Policies Environmental Zero Tolerance Laws Problem Identification and Referral Project SUCCESS Problem Identification and Referral Teen Intervene

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

#### Narratve Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

#### Evaluation

f)

1. Does your state have an evaluation plan for substance use disorder prevention that was developed within  $j \cap Yes j \cap No$  the last five years?

If yes, please attach the plan in BGAS by going to the Attachments Page and upload the plan

- 2. Does your state's prevention evaluation plan include the following components? (check all that apply):
  - a) Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks
  - b) **b** Includes evaluation information from sub-recipients
  - c) b Includes SAMHSA National Outcome Measurement (NOMs) requirements
  - d) Establishes a process for providing timely evaluation information to stakeholders
  - e) E Formalizes processes for incorporating evaluation findings into resource allocation and decision-making
    - Other (please list:)
      - 1. Reports to sub-recipients

2. Evaluation of trainings offered by DBHR

- g) 🗧 Not applicable/no prevention evaluation plan
- 3. Please check those process measures listed below that your state collects on its SABG funded prevention services:
  - a) b Numbers served
  - b) **b** Implementation fidelity
  - c) B Participant satisfaction
  - d) B Number of evidence based programs/practices/policies implemented
  - e) 6 Attendance
  - f) Demographic information
  - g) Other (please describe):

1. Service hours

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

- a) 🗧 30-day use of alcohol, tobacco, prescription drugs, etc
- b) 🦻 Heavy use
  - e Binge use
    - e Perception of harm
- c) e Disapproval of use
- d) e Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)
- e) e Other (please describe):

State of WASHINGTON Substance Abuse Prevention and Mental Health Promotion

Integrating community substance abuse prevention and mental health promotion across Washington

# Five-Year Strategic Plan

Washington State Prevention Enhancement Policy Consortium August 2012 updated November 2015

# **Table of Contents**

| Ackno | owledgements  |                  |
|-------|---|------------------|
| Chapt | er One: Executive Summary   | 5                |
| Chapt | er Two: Prevention Background   | 7                |
| Sect  | tion 1: Overview of Prevention  | 7                |
| Sect  | tion 2: Risk and Protective Factors   | 7                |
| Sect  | tion 3: Adverse Childhood Experiences                                       |                  |
| Sect  | tion 4: Strategic Prevention Framework (SPF)                                | 9                |
| Chapt | er Three: Strategic Plan  |                  |
| Sect  | tion 1: Getting Started   |                  |
| Sect  | tion 2: Capacity Building   |                  |
| Sect  | tion 3: Assessments of State Substance Use and Mental Health Disorders Data | and Resources 21 |
| Sect  | tion 4: Plan for Action (Goals, Objectives, and Strategies)                 | 29               |
| Sect  | tion 5: Implementation  |                  |
| Sect  | tion 6: Evaluation  |                  |
| Apper | ndix  | 53               |
| 1.    | List of Agencies Acronyms and Abbreviations                                 | 53               |
| 2.    | SPE Consortium Partner List   |                  |
| 3.    | Brief Overview of Strategic Prevention Framework (SPF)                      | 55               |
| 4.    | Washington State Key Data Sources   | 58               |
| 5.    | Data Assessment   | 60               |
| 6.    | Learning Community Steering Committees                                      |                  |
| 7.    | Logic Model – Updated 2015  |                  |
| 8.    | Prevention Consortium Team Accomplishments 2013-2015                        |                  |
| 9.    | Significant Events Influencing the Field of Prevention from 2010-2015       |                  |

#### ACKNOWLEDGEMENTS

It is with great pleasure that we have joined efforts to present this *Washington State Prevention Enhancement Policy Consortium Substance Abuse Prevention and Mental Health Promotion Five-Year Strategic Plan update*. We are committed to providing the best service to the children, individuals, families, and communities of our state.

We have updated this plan after conducting a scheduled need and resources assessment. Through implementation of this plan, we continue to build the health and wellness of individuals, families, schools, and communities where people can be as healthy as possible in a safe and nurturing environment.

We would like to give special thanks to all of the partnering state and tribal agencies and organizations and to those individuals who participate as representatives serving on the State Prevention Enhancement Policy Consortium. A complete list of representatives can be found in the Appendix -*SPE Consortium Partner List* page 54.

Additionally we would like to acknowledge Chris Imhoff, Director for the Division of Behavioral Health and Recovery, for her support in this endeavor. Director Imhoff is an avid supporter of prevention efforts and we appreciate her continued encouragement for us to move our field forward to meet the demanding needs in the future of integrated continuum of care.

Lastly, we would like to thank each of you who participated in the various information gathering opportunities through meetings, discussions, and review of documents for this plan originally and with the update.

We are honored to do this work on behalf of all of the citizens of Washington State.

Sincerely,

David Hudson, *Co-Chair SPE Policy Consortium* Section Manager, Community-Based Prevention Office of Healthy Communities Division of Prevention and Community Health Department of Health

Sarah Ma<sup>r</sup>iani, *Co-Chair SPE Policy Consortium* Behavioral Health Administrator Division of Behavioral Health and Recovery Department of Social Health Services

# **Chapter One: EXECUTIVE SUMMARY**

#### Integrating community substance abuse prevention and mental health promotion across Washington.

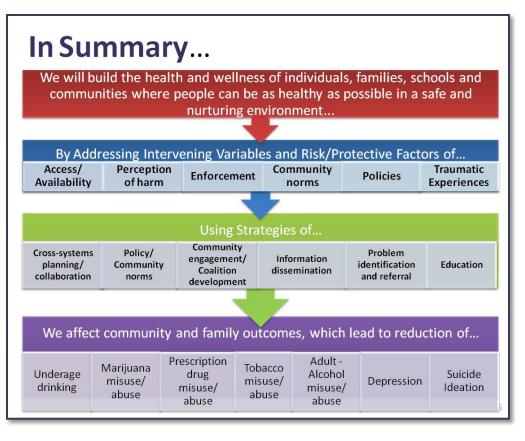
The Washington State Prevention Enhancement Policy Consortium (hereafter referred to as the Consortium) is comprised of representatives from 26 state and tribal agencies and organizations. The goal of the Consortium is that through partnerships we will strengthen and support an integrated statewide system of community-driven substance abuse prevention, mental health promotion, and related issues.

The Consortium held our first meeting in October 2011 and initiated our strategic planning process in which we conducted an extensive review of state-level data and resources. Through this process, we were able to identify problem areas, as well as map current resources and partnerships that support substance abuse prevention and mental health promotion. Furthermore, we selected collaborative strategies from which to move forward in developing detailed Action Plans for each of our prioritized problem areas. In addition to supporting the current work of our partnering state and tribal agencies and organizations, as well as local communities, the Consortium is using strategies focused on public campaigns, policies, and professional development that will capitalize on the unique role of a state-level coalition to contribute to the overall collective impact.

The diagram to the right is a summary of the key elements of our plan. The top box captures our overall intended *impact*; followed by the *intervening variables* we will focus on that lead us to the alignment of our *strategies* in order to

strategies in order to create change in our identified problem areas.

This plan includes a brief overview of the history and research that support our plan and documentation of the discussion along



with conclusions and summation of decisions for each step of the strategic prevention framework planning process. We have included an extensive appendix for reference of the working products we used throughout this process.

The Consortium looks forward to the implementation of this plan as an opportunity to infuse energy into our system as we enhance our capacity to support community level strategic prevention planning and service.

In this 2015 edition of the plan we have updated the needs and resources assessment information and confirmed our priorities. We have updated the Team Action plans and made serval updates for context as noted throughout. We have made progress in many areas, as reflected in the accomplishments section, and will continue to look forward to further implementation and collaboration to sustain the substance abuse and mental health promotion efforts in Washington State.

This document is intended to summarize key discussions and decisions of the process and work of this plan. For more information about the State Prevention Enhancement projects and planning, go to <u>www.TheAthenaForum.org/SPE</u>.

### **Chapter Two: PREVENTION BACKGROUND**

#### **Section 1: Overview of Prevention**

The field of substance abuse prevention science has evolved quite significantly over the past twentyfive years and continues to progress as we consider the influence of current trends, including integration with mental health promotion. We have continued to build on our strong foundation of research-based practices focused on individual interventions as well as expand our focus to community-level interventions and outcomes.

According to the Preventing Mental, Emotional and Behavioral Disorders Among Young People Report<sup>1</sup> (also known as, *IOM Report*), prevention is specifically defined as, "Interventions that occur prior to the onset of a disorder that are intended to prevent or reduce risk for the disorder." Mental health promotion is defined as, "Interventions that aim to enhance the ability to achieve developmentally appropriate tasks (developmental competencies) and a positive sense of self-esteem, mastery, well-being, and social inclusion and to strengthen the ability to cope with adversity."

The prevention field relies heavily on research and practice working in concert to inform our work to effectively create positive outcomes in building healthy families and communities. In Washington State, we follow the national guidance that encourages use of evidence-based practices. Within this framework, we also recognize the value of supporting efforts and programs that include adaptations and innovations that meet culturally relevant needs: for example, the twenty-nine federally recognized tribes in our state are using programs that are unique to their needs. While there are a number of conceptual frameworks included in substance abuse prevention, three key concepts of the current prevention work are: risk and protective factors, adverse childhood experiences, and the Strategic Prevention Framework.

#### Section 2: Risk and Protective Factors

Risk and protective factors provide the underlying framework upon which much of prevention research and practice is based. Although various research frameworks may be more general or specific depending on the research and intent of focus, the IOM Report<sup>2</sup> defines risk and protective factors broadly as follows:

<u>Protective factor</u>: A characteristic at the biological, psychological, family, or community (including peers and culture) level that is associated with a lower likelihood of problem outcomes or that reduces the negative impact of a risk factor on problem outcomes.

<u>Risk factor</u>: A characteristic at the biological, psychological, family, community, or cultural level that precedes and is associated with a higher likelihood of problem outcomes.

<sup>&</sup>lt;sup>1</sup> National Research Council and Institute of Medicine of the National Academies, 2009. <u>http://www.iom.edu/Reports/2009/Preventing-Mental-Emotional-and-Behavioral-Disorders-Among-Young-People-Progress-and-Possibilities.aspx</u>. Accessed July 2012.

<sup>&</sup>lt;sup>2</sup> National Research Council and Institute of Medicine of the National Academies, 2009. (A list of risk factors can be found in the IOM Report Appendix E page 521.)

Risk and protective factors for substance abuse and mental health disorders are often categorized into four domains: individual, family, school, and community. Within each of these domains there are various factors that have been shown to either increase (risk factors) or decrease (protective factors) the likelihood of an individual developing problem behaviors such as substance abuse. Generally speaking, a greater number of risks present compounded by fewer protective factors is associated with greater chance of problem behaviors developing. Conversely, less risk supported by greater presence of protection increases the likelihood of healthy development.

The essence of prevention practice is to decrease risk and increase protection through our efforts to create positive individual and community change.

### Section 3: Adverse Childhood Experiences

More recently within the prevention field we have begun to recognize and integrate information provided regarding adverse childhood experiences (ACEs). The initial ACEs study was conducted at Kaiser Permanente in collaboration with the Center for Disease Control and Prevention (CDC) from 1995 to 1997<sup>3</sup>. Since the release of this study, over 50 scientific articles have been published which continue to inform our efforts.



This diagram represents the conceptual framework of ACEs<sup>4</sup>:

ACEs fall within two categories: abuse (physical, sexual, and verbal) and household dysfunction (substance abuse, parental separation/divorce, mental illness, battered mother, and criminal behavioral). Research has shown that there is a strong relationship between ACEs and a number of problem behaviors including age of first use and any alcohol use.<sup>5</sup> The ACEs study seeks to understand the frequency of problem behaviors present in our communities based on the underlying relationship of initiation of risky behavior by an individual. By helping to identify more specifically the underlying causes related to adoption of certain behaviors by individuals, we can build on our knowledge of risk

<sup>5</sup> Adverse childhood experiences and the association with ever using alcohol and initiating alcohol use during adolescence, 2006. Dube SR, Miller JW, Brown DW, Giles WH, Felitti VJ, Dong M, Anda RF. -

<sup>&</sup>lt;sup>3</sup> Adverse Childhood Experiences, Center for Disease Control and Prevention, 2011 - <u>http://www.cdc.gov/ace/index.htm</u>. Accessed July 2012.

<sup>&</sup>lt;sup>4</sup> Adverse Childhood Experiences, Center for Disease Control and Prevention, 2011

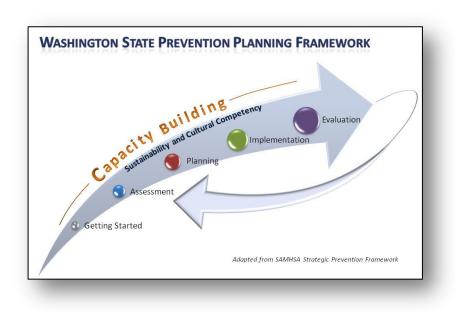
http://www.ncbi.nlm.nih.gov/pubmed/16549308?dopt=Abstract. Accessed July 2012.

and protective factors to provide insight into the development of specific strategies in certain populations and increase the potential for successful outcomes.

## Section 4: Strategic Prevention Framework (SPF)

The Consortium used the Prevention Planning Framework that is based on the Strategic Prevention Framework (SPF) as our overall planning framework for this process. The SPF was originally developed by the federal Substance Abuse and Mental Health Services Administration (SAMHSA)<sup>6</sup>. SAMSHA's Strategic Prevention Framework is a comprehensive planning process designed to help states and communities build the infrastructure necessary for effective and sustainable prevention. Based on learning from the Strategic Prevention Framework State Incentive Grant process, we have slightly adapted this framework for the purposes of prevention planning in Washington State. The Prevention Planning Framework is comprised of the following key elements that contribute to more meaningful strategic plans:

- <u>Getting Started:</u> Initiate the process.
- <u>Capacity</u>: Mobilizing our state system and building capacity.
- <u>Assessment:</u> Assess our state's needs, resources, readiness, and gaps.
- <u>Planning</u>: Develop a strategic prevention plan.
- <u>Implementation</u>: Implement evidence-based prevention strategies.
- <u>Reporting and Evaluation:</u> Evaluate and monitor results, change as necessary.
- <u>Cultural competence</u>
- <u>Sustainability</u>



In using this framework, we are able to capitalize on the benefits of an outcome-based coordinated state plan. We have broad involvement and ownership in the process of this plan, leading to mutually agreed-upon focus and priorities. In 2011 we conducted a data-informed assessment of needs and resources to support our selection of strategies that are research-based programs, policies, and practices that build on existing resources and guide our evaluation strategy.

<sup>&</sup>lt;sup>6</sup> Substance Abuse Mental Health Services Administration (SAMHSA), 2011 - <u>http://www.samhsa.gov/prevention/spf.aspx</u>. Accessed July 2012.

In 2013 we again examined the most current data available and made minor updates to this plan. In 2015 we updated this plan following a data-informed needs and resources assessment to examine and continue to support selected strategies. There are various places where the 2015 updated information or data is provided while we left the background and original information intact within the plan narrative.

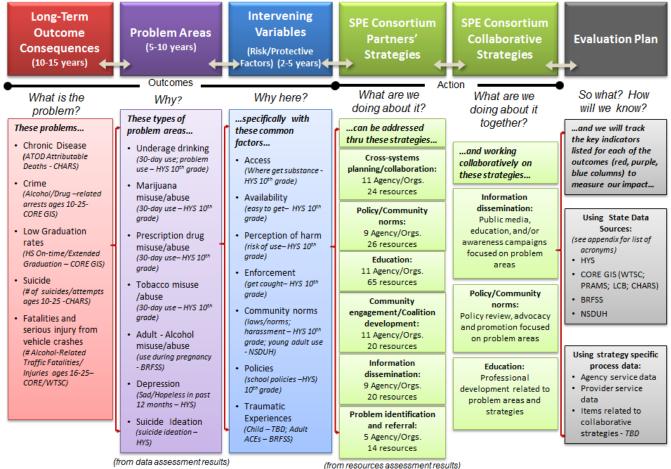
The remainder of this document will highlight the Consortium's key discussions and strategic decisions in relation to the components of the Prevention Planning Framework based on the Strategic Prevention Framework.

# **Chapter Three: Strategic Plan**

Beginning in October 2011, the Policy Consortium worked collaboratively to establish a structure, review data, examine state-level resources, and develop the following strategic plan. While we have made considerable effort to be inclusive and gather the best information available for our planning, we also recognize that this plan will be used as the foundation for ongoing planning as we move into the future. It is important that we continue to review, analyze, and update the strategies within this plan to meet the most relevant needs of our time.

#### Logic Model - Updated 2015

# SPE Policy Consortium State Plan Logic Model



The logic model was developed to provide an overview of the central elements of our Strategic Plan. (For a full page view, see Appendix 8- Logic Model page 118.) This logic model overlays various logic model planning frameworks that are used by the Consortium partners. Furthermore, this logic model format is being used to promote strategic planning in local community coalitions through the Community Prevention and Wellness Initiative (CPWI).

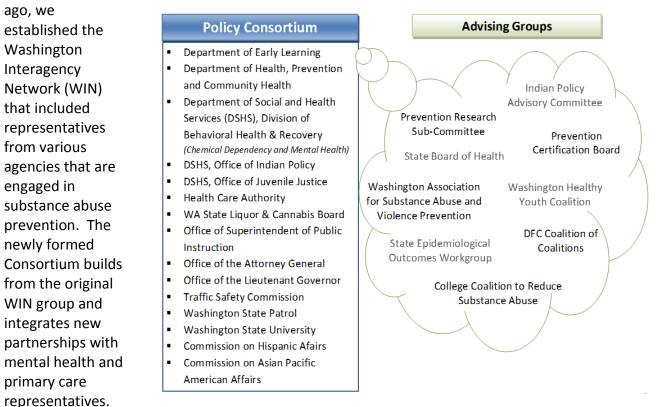
The first three columns of the logic model, *Consequences, Behavioral Health Problems,* and *Intervening Variables,* pull together the prioritization from the data assessment. The fourth column,

*SPE Consortium Partners' Strategies,* summarizes the information from the resources assessment. The second green column, *SPE Consortium Collaborative Strategies*, lists the specific strategies that we are developing as collaborative projects for the Consortium to implement. The last column, *Evaluation Plan*, records the sources for information we intend to collect and analyze as part of our continuous review of the plan. The process for decision-making and conclusions for each piece of this logic model are explained in the following sections.

#### **Section 1: Getting Started**

#### **Policy Consortium Structure and Organization**

In October 2011, we convened the first meeting of the Consortium. Washington state agencies have a history of collaborating in a variety of venues for planning and implementing projects. Over 20 years



(A complete, current, list of Consortium members can be found in the Appendix 2 - *SPE Consortium Partner* List, page 54.)

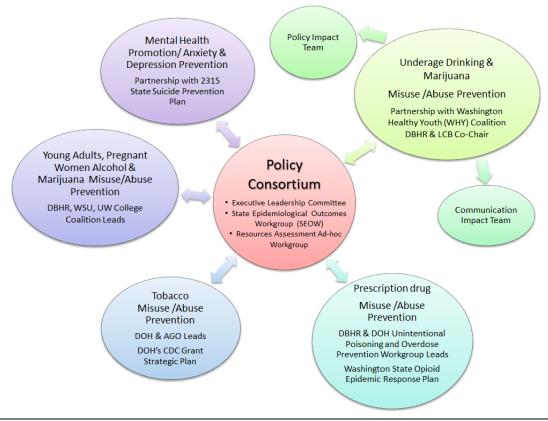
The Consortium is responsible for the state-level planning and implementation of collaborative strategies to address substance abuse prevention and mental health promotion. The Consortium has the unique role of a state-level coalition to implement strategies that contribute to an overall collective impact for our state. In December 2011, we completed our Capacity Building Plan followed by the competition of this Five-Year Strategic Plan in August 2012. The Consortium functions as a state-level inter-agency/organization, consensus-driven coalition. As needed, we use *Robert's Rules of Order* for formal decision making.

The Consortium meets most months of the year and is currently co-chaired by the Department of Health, Division of Prevention and Community Health, and the Department of Social and Health Services, Division of Behavioral Health and Recovery. The Consortium has a Leadership Committee, which provides direction and guidance to ensure that the goals and objectives of the Strategic Plan are met. Beginning with the next election cycle, the Consortium Leadership will consist of Co-chairs: one from a state public agency and one from a statewide organization. To increase continuity and focus, the co-chairs will serve staggered two-year terms, with annual elections to replace the outgoing co-chair. The Consortium also has an ad-hoc SPE Data, Resources Assessment and Evaluation Workgroup led by the State Epidemiological Outcomes Workgroup. This workgroup meets quarterly to conduct annual assessments and to consider and oversee evaluation.

The Consortium has also established the following Action Plan Teams to develop and implement plans for each strategy related to each problem area:

- Underage Drinking & Youth Marijuana Misuse/Abuse Prevention Team Washington Healthy Youth (WHY) Coalition
- Prescription Drug Misuse/Abuse Prevention Team
- Tobacco Misuse/Abuse Prevention Team
- Young Adults & Pregnant Women Alcohol & Marijuana Misuse/Abuse Prevention Workgroup
- Mental Health Promotion/ Anxiety & Depression Prevention Team

This diagram shows our implementation structure- updated 2015.



# **Consortium Structure**

Page **13** of **130** 

The Consortium created Action Plan Teams to oversee the implementation of Action Plans focused on each of our identified problem areas in order to accomplish the goals and mission laid out in a strategic plan. Action Plan Teams are the principal vehicles through which Consortium members collaborate on a sustained and formal basis to realize the Consortium's strategic goals. Teams pursue an Action Plan that is revised annually and submitted to the Consortium for review and approval. Action Plans outline the goals to promote policies, projects, and partnerships for issues under jurisdiction of the working group. Action Plan Teams develop and implement plans for strategies related to each problem area. Because the partners and strategies are similar for both underage drinking and marijuana, the previously established Washington Healthy Youth (WHY) Coalition will serve as the Action Plan Team for both problem areas.

#### **Membership Recruitment and Retention**

Consortium members are expected to:

- Participate in a minimum of 2/3 of the meetings within a calendar year.
- Represent the Consortium at other meetings.
- Be aware of the state system of support and seek opportunities to actively support implementation and coordination of the Strategic Plan.
- Stay current listen to 'what is going on' regarding substance abuse prevention and mental health promotion.
- Think about how projects/programs align with their agency interests, goals, programs, and projects, advise on possible state implications.
- Explore opportunities for collaboration and coordination.

Through active engagement and intentional recruitment, the Consortium is ensuring representation of key state agencies and organizations in our ongoing work.

To encourage active participation, we make a significant effort to provide accurate and timely communication with all of our members and the advisory groups. We keep them updated on the Consortium's efforts and help them to clearly understand their contributions to these efforts. Members and partners have opportunities to volunteer or be selected for leadership and committee positions.

The Consortium recruits new members as needed. In the event that an individual can no longer participate, we recruit a replacement from that agency/organization. As new state-level agencies or organizations are created or directed to work on these issues, we recruit their participation. We use existing partnerships and connections to invite participation of new members. As new members join the Consortium or a specific project, we meet with them to provide an orientation to our efforts. We also actively follow up with them after their initial meeting to answer their questions and provide additional information as needed.

#### Summary of the key decision-making processes and findings

The Consortium worked collaboratively for ten months to complete the Five-year Strategic Plan and continues to work to implement the goals and strategies outlined in the Plan. When we received the SPE grant in October 2011, we convened the first meeting of Consortium. Our focus for fall 2011 (November through January) was to cover the general framework of strategic prevention planning and

build readiness for the Consortium to conduct our assessments and planning. We conducted our Data Needs Assessment beginning in March 2012, and continuing through April 2012. Our Resources Assessment followed in April 2012, and concluded in May 2012. On June 11, 2012, we held an all-day planning session to review the findings from our assessments and develop the strategies and activities for our plan. Following the planning session, we began drafting this plan and seeking input. On June 12, 2012, we met with tribal leaders for a roundtable discussion meeting prior to a formal tribal consultation in July 2012. Additionally, we met with the community stakeholders which included representatives from counties, local health jurisdictions, treatment providers, healthcare plan providers, educational service districts, and coalitions to seek feedback into the proposed plan. In September 2012, the Consortium formed Learning Community Steering Committees to review in depth each problem area and prepare Action Plans for the Consortium to review and approve. In December 2012, the Consortium held a two-day planning meeting to conduct presentations on each problem area and propose and review Action Plans. Based on this review, the Consortium prioritized our 1-year Action Plans. Each year we update the 1-Year Action Plans to make sure we are meeting our goals.

In 2015, we began to update the strategic plan by conducting our Resources Assessment from February 2015 to June 2015. To update our needs assessment, we convened an ad-hoc work group in April 2015 to review statewide data presented by the State Epidemiological Outcomes Workgroup (SEOW). Nine Consortium members and staff participated and completed the review by June 2015. Following the process used in 2012, the Consortium held an extended planning session. During this session the group reviewed outcome measures, environmental changes and impacts, and youth consumption trends. From this session new target Intermediate Outcome goals were set for several Behavioral Health Problems, and each workgroup updated their annual Action Plan. See page 32.

#### **Mission Statement and Key Values**

Integrating community substance abuse prevention and mental health promotion across Washington.

**Mission:** The Consortium, through partnerships, is working to strengthen and support an integrated statewide system of community-driven substance abuse prevention, mental health promotion, and related issues.

The Consortium established and agreed to the following **key values** as critical components of all of our work:

- Build community wellness through substance abuse prevention and mental health promotion.
- Make data-informed decisions.
- Consider the entire lifespan of the individual.
- Support community-level initiatives.
- Ensure cultural competence, including honoring the Centennial Accord between the Federally Recognized Indian Tribes in Washington State and the State of Washington.
- Address health disparities.
- Work collaboratively to produce a collective impact.
- Consider impacts of Health Care Reform and Indian Health Care Improvement Act.
- Honor current state and tribal resources that support substance abuse prevention/mental health promotion.

### Section 2: Capacity Building

#### **Outreach and Sustainability**

The Consortium partners have committed to attending bi-monthly meetings along with supporting the collaborative efforts and strategies identified in this plan. Additionally, each partner has identified the specific resources that it devotes to supporting substance abuse prevention and mental health promotion. (See Appendix - *Matrix of Resources Identified in Resource Assessment focused on* beginning on page 111.)

Furthermore, the Consortium is committed to working in concert with other state and tribal agencies, organizations, and advisory groups, to support our strategies and objectives. We recognize the value of staying informed of the efforts of other groups including the Behavioral Health Advisory Council; Community Transformation Grant Leadership Team; System of Care Family, Youth and System Partner Roundtables; Association of Counties Human Services Prevention Sub-committee; and Federally Recognized Tribes as well as other non-traditional groups such as youth prevention groups, local coalitions, and foundations. We will also consult with the community at large as we further develop our specific activities within each strategy to gather community input and create partnerships.

In addition to the commitments from each of the partnering agencies and organizations, the Division of Behavioral Health and Recovery (DBHR), as the "Single State Agency" responsible for substance abuse prevention and mental health promotion, is committed to supporting strategies and activities of the Consortium's plan with their Substance Abuse Prevention and Treatment (SAPT) Block Grant funding. The plan is in overall alignment with DBHR's goals and objectives and is seen as a guiding framework. Additionally, we intend to capitalize on opportunities to further integrate funding systems in the state, such as mental health block grant funding, to support integration of mental health promotion among substance abuse prevention providers.

# An agreed-upon-formula for allocating state substance abuse prevention resources to identified communities of greatest need.

The Consortium agrees that substance abuse prevention and mental health promotion resources should be directed toward local programs and communities that demonstrate highest need and capacity to address need based on data-informed decisions. Furthermore, we support the continued use of evidence-based practices while honoring the value of adaptations and innovations that appropriately address culturally-specific prevention needs. Lastly, we recognize the importance of supporting local community coalitions in strategic planning to address these issues most effectively.

DBHR serves as the Washington State Single State Agency for the federal substance abuse prevention resources, also known as the state SAPT Block Grant.

This funding is allocated to communities of need through three main methods:

1) Funding is distributed to federally recognized tribes based on a formula, taking their enrolled membership into account.

2) Funding is distributed to county governments based on formula, which includes calculations for population and is allocated to the identified highest need community (Community Prevention and Wellness Initiative (CPWI) Communities). Highest need communities are identified based on a Risk Profile prepared by the State Epidemiological Outcomes Workgroup (SEOW) and provided to the counties and educational service districts. 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.

3) Funding is distributed to the Office of Superintendent of Public Instruction (OPSI) to direct school-based prevention/intervention resources into the selected high-need communities.

#### **Training/Technical Assistance**

In Washington State, the prevention field is supported by an annual statewide prevention conference as well as a number of more local opportunities for training and technical assistance provided through tribes, government agencies, educational service districts, and local communities. While our workforce has a vast array of education and experience, we also recognize that there are always new developments in the science and practice.

The Consortium is committed to ongoing capacity building in our state to support a strong, relevant, and vital substance abuse prevention and mental health promotion workforce.

According to our baseline resources assessment, Consortium partners collectively have provided an additional 420 training/technical assistance activities in 2012. Over 50 hours of training was also conducted with SPE grant funds. We have developed the internal capacity to create, conduct, and record online trainings. We have established and added to an online e-learning environment, with content that is available at no-cost to our providers. This e-learning system not only provides online training and education opportunities, it tracks continuing education hours to provide documentation for professional certification and renewal. We plan to add a minimum of 20 hours of new content each year; this is congruent with the requirements for the bi-annual prevention professional certification renewal. Overall, we expect to increase our capacity for providing trainings/technical assistance activities by 20% by State Fiscal Year 2016. With the successful award of the Substance Abuse and Mental Health Services Administration's Partnerships for Success 2013 discretionary grant, we have achieved this goal.

In 2013, using the SPE grant we completed a number of valuable infrastructure enhancements to our systems to provide consistent professional training across our state agencies and community partners, provide a more accessible and responsive data collection system, and integrate primary care with substance abuse prevention. These enhancements build on our state infrastructure by increasing the capability of state staff to provide training and technical assistance to the field and support prevention professionals directly.

In 2013, we built new elements within our various data systems that are supported by online training/technical assistance modules. This will provide information and guidance to local community

providers to accurately and successfully use community-level data and service provision data in their planning efforts.

In 2013, we completed updates on two valuable training curriculums used in our state: the Office of Superintendent of Public Instruction's *Washington's Student Assistance Prevention and Intervention Services Program Manual* and the Department of Commerce Community Mobilization's *Art and Science of Community Organizing Training*. Both manuals now include updated information to address special populations, mental health promotion, primary care integration, and new areas of substance abuse including prescription drug abuse.

And finally, through our Primary Care Demonstration Project, we worked in partnership with nine local communities to discover and evaluate successful strategies to 1) include and encourage active participation of a primary health care provider in coalition meetings, activities, and representation of coalition goals in the community, and 2) integrate and collaborate between coalitions and primary health care provided documentation and presented their findings at our 2012 Prevention Summit so the state and local-level providers can learn from their efforts. The Department of Health will incorporate relevant information into its Community Health Care online worker training and patient-centered health home quality improvement worker trainings. In the coming years, we will also establish additional methods for disseminating the lessons learned through this process.

In addition to continuing to support the successful strategies, we already have in place for training and technical assistance, we will expand available training. The Consortium collaborative strategies include a significant focus on, "Professional development across all systems." This strategy includes training topics such as assisting new coalitions/providers to get 'up to speed' on state system and coalition frameworks ('new professional orientation'); education for broad networks of providers (prevention, mental health, and primary care) regarding mental health across the spectrum, including the connection to adverse childhood experiences; and education for state systems regarding the patient-centered health home training and the role of Health Care Authority.

As part of our Action Plans, we will develop methods to build readiness and capacity in additional highneed areas to be considered for funding in the future. Although there are current efforts to focus services in high-need areas, we are often faced with the challenge of high-need communities not being 'ready' for services, and thus not able to access the resources we make available. We have discussed how we can improve our ability to support these communities with services to get them 'ready' to receive resources to address these problem areas. Specifically, we will look to areas that have high needs but do not have the formal structures in place to respond to opportunities such as requests for proposals, or similar granting processes. We will continue to develop capacity within state staff and our local provider network to reach out to these areas and capitalize on the informal structures that can be grown to support more formal and organized planning and services for these communities.

The Consortium will ensure that education pieces are culturally specific and science-based while also supporting innovative development of evidence-based practices.

#### Workforce Development

In an effort to prepare for the opportunities that may become available through health care reform and to continue to advance our field, the Consortium reviewed three components of the current structure of our workforce. In 2011 we commissioned feasibility studies on individual prevention professional certification, agency licensure, and rate setting for prevention services. We asked each study to provide information about the current state system, what other states have done, the readiness of the field to meet requirements, the steps necessary for the state to consider for implementation, options for the state to consider, benefits and challenges to making the change, and how recommendations relate to the various potential impacts of health care reform. The following information provides an overview of each study's key findings and conclusions. For copies of the full reports go to www.TheAthenaForum.org/SPE.

#### **Individual Prevention Professional Certification**

In Washington, the Prevention Specialist Certification Board of Washington (PSCBW) is the certifying body for Certified Prevention Professionals (CPP). Some counties and local agencies require certification within the scope of their contracts and/or hiring practices; however, there is not a state requirement for certification of individuals. The Division of Behavioral Health and Recovery contracted with Spokane Falls Community College (SFCC) to conduct a professional certification feasibility study. SFCC reviewed other states with certification or agency requirements; interviewed national contacts, Washington State stakeholders, and coalition coordinators; and administered an online survey. The survey covered 120 contacts from eleven counties and six tribes with an 80 percent response rate.

In summary, SFCC found that while the PSCBW has a high-quality system set up for certifying individuals, as a voluntary board, without staff support, they may not have the capacity to respond if a requirement for certification were put into place. Furthermore, it is important to work with the other certifying bodies in the state so as to not unnecessarily duplicate processes. Additionally, it is important to consider the level of experience of the current prevention professionals in addition to their formal training and education. Based on the results of the online survey, there is a broad distribution of education and length of experience with the majority of current professionals having worked between 5-10 years (26.1%) followed by 10-15 years (15.2%).

Since the final report we have employed several of the report recommendations to elevate the level of education for prevention professionals. The report suggests that it is important to increase access to training for new providers by providing webinars, video training, and distance learning as well as working with higher education to develop prevention certificate or degree programs. We have provided several webinar series on strategic plan development, understanding community data and have provided annual Coalition Leadership Institute trainings since 2012. There are now a variety of training modules available as well as templates and slides for community education on prevention. There are quarterly Substance Abuse Prevention System Training available to providers as well. Washington State University now has a Interdisciplinary PhD Program in Prevention Science. The report recommended that in addition to the already established Certified Prevention Professional, the state consider providing opportunities for various levels of credentialing such as General Prevention Specialist or Associate Prevention Provider. Since 2011 we have worked with the PSCBW and there is now an APP available.

In July 2015, the Division of Behavioral Health and Recovery began to require that Community Coalition Coordinators participating in the Community and Wellness Prevention Initiative (CPWI) be Certified Prevention Professionals (CPP) by the PSCBW. The intent of this change is to advance the prevention professional workforce and increase the local capacity to provide effective prevention programming across the state.

#### **Agency Licensure**

SFCC conducted an agency licensure feasibility study in conjunction with the professional certification study. There are approximately 375 agencies in Washington that currently provide prevention-related services. Washington State does not currently require prevention agencies or organizations to have a license in order to provide substance abuse prevention services. Although a few states have tiered staffing requirements in prevention contracts, very few states have agency licensure for prevention. In review of our current systems and in consideration of developing a structure, new rules to establish administrative standards for licensing would need to be proposed. SFCC recommends partnering with the established behavioral health stakeholder workgroup that is reviewing the Washington Administrative Code (WAC) to propose including prevention in the code. It was also suggested that we consider using the tiered certification structure to support staffing requirements within agency licensure. In conclusion, while SFCC does recommend that we consider moving toward agency licensing, it is a process that will require careful examination before being implemented. As of 2015, no action has been taken regarding Agency Licensure.

#### **Prevention Service Rate Setting**

Washington State does not currently have set rates for substance abuse prevention services. Mercer Government Human Services Consulting (Mercer) was hired to conduct a study to examine the feasibility of establishing service rates for substance abuse prevention services. Their study included contact with fourteen states and interviews with representatives from five states (Illinois, Louisiana, New Jersey, South Dakota, and Tennessee) and three prevention experts.

Based on these interviews, Mercer was able to summarize key successes and challenges other states faced in establishing rates for substance abuse prevention services. While it was shown to noticeably increase accountability, improved reporting, efficiencies, and defined target audience, it was sometimes challenging for providers to bill and report using the technology required for tracking. Getting specific cost information and identifying the components of rates is critical for the success of the project. A few of the states' rates include a mixture of fee-for-service and cost reimbursement which allows for accounting on planning and reporting in addition to direct service. This study was helpful in providing the Consortium with a number of thoughtful points for consideration as we move forward in our deliberation of rate setting, including availability of state staffing resources, contracting regulations, capacity of current management information system to accept claims, steps needed to identify codes for prevention, timeline, involvement of stakeholders in the process, variance of rates by program or by category, and components the rates would include.

The information from all three studies was presented to the Consortium for review. The Consortium decided that based on the scope of work associated with these changes, that Individual Prevention Professional Certification would be the priority for Workforce Development.

# Section 3: Assessments of State Substance Use and Mental Health Disorders Data and Resources

The Consortium conducted state-level assessments of both need and resources. We solicited the State Epidemiological Outcomes Workgroup (SEOW) to gather relevant data and provide information to the Consortium for review for our data assessment. Additionally, we formed a Resources Assessment Workgroup specifically to develop and prepare the resources assessment. Both workgroups gathered information and presented it to the full Consortium for review, discussion, and decisions for our strategic planning. We also collected and reviewed information about significant historical events, economic changes, policy/law changes, and major changes to funding resources/directives that may have impacted either our data indicator elements or explanation of resources. Results of each assessment follow.

As noted earlier, the Consortium conducted a state-level needs and resources assessment in 2015. As done for the previous assessment, we solicited the SEOW group to gather comparative data and the SEOW presented their findings to the entire Consortium. The Consortium formed a workgroup to review discuss key findings from the 2014 Healthy Youth Survey student survey data trends and Core GIS data, as available. The resources assessment update was conducted this year using an online survey. The survey was offered to all Consortium members, and was completed by 18 agencies. The assessment workgroup presented resource and needs assessment workgroup findings to the full Coalition for further discussion and decision making.

#### **Data Assessment**

To provide recommendations to the Consortium, the SEOW convened the SPE Data Workgroup to review the epidemiological data regarding substance use and mental health. The SPE Data Workgroup included partners from Department of Health, Division of Prevention and Community Health; Department of Health and Social Services, Division of Behavioral Health and Recovery; and Washington Traffic Safety Commission.

The workgroup examined data by age, race, ethnicity, and socioeconomic indicators based on prevalence rates, long-term trends, economic impact, and social impact including mortality, morbidity, traffic safety, effects on newborns, and school related consequences.

#### **Key Findings:**

The SPE Data Workgroup came to the following summary conclusions:

- Overall, based on the prevalence, social and economic indicators above, alcohol ranks highest
  of substance use problems, followed by marijuana (2nd), and tobacco (3rd), and lastly
  prescription drugs (4th). We also included a review of methamphetamine (meth) use, which
  has the least overall impact of these five substances, yet, remains a concern as it is perceived to
  have high prevalence in specific populations and areas. (For more information, see Appendix Data Assessment page 60.)
- Based on the prevalence, trends, and impact of substance use, underage drinking remains the number one priority for prevention.
- Marijuana is ranked second due to high prevalence use among youth.

 Both substance use and mental health disorders are more prevalent among youth and young adults, and therefore our efforts should be focused on this age range.

#### Analysis and Prioritization of Data:

The data conclusions and recommendations related to substance misuse/abuse and mental health indicators were presented to the Consortium in three consecutive meetings (*see Appendix - Data Assessment page 60*).

Long-Term Outcome Consequences (10-15 years)

What is the problem?

In consideration of the recommendations and conclusions provided by the SPE Data Workgroup, we also looked to answer the broader question of "*What are the problems we are intending to address?*" After much discussion about the various implications that these substance use and mental health disorders have on society, we decided to focus on five *long-term outcomes consequences*, 1) chronic diseases related to alcohol and tobacco; 2) crime; 3) low high school graduation rates; 4) teen and young adult suicide; and 5) fatalities and serious injury from traffic crashes.

#### Problem Areas (5-10 years)

Why?

After a thorough review and discussion of the data assessment, the Consortium decided to focus on the following intermediate outcomes also known as *problem areas*:

#### Substance Abuse

The Consortium decided to focus on the top four ranked misused/abused substances: alcohol, marijuana, tobacco, and prescription drugs. Based on the prevalence by age, underage drinking remains the top priority. Additionally, the Consortium agreed that specific emphasis also be placed on strategies related to alcohol use prevention for the 18-25 year age range. It was noted that there are high rates of drinking during pregnancy, especially among white women over the age of 35. And lastly, the Consortium noted the importance of continuing to watch "trending" substances such as heroin, which has recently shown increased use, hypothesized to be related to the reformulation of prescription opiates.

It was decided to use the term 'misuse/abuse' to account for important distinctions related to each substance. Specifically, in regards to marijuana it is important to note that medical marijuana use is legal in this state; therefore not all marijuana use is considered abuse. Similarly prescription drugs when taken as prescribed, are not considered harmful or misuse/abuse. In regards to tobacco, it is important to recognize that in some cultures, tobacco is used for cultural traditions and ceremonies and would not be considered misuse or abuse.

#### Mental Health

The review of mental health indicators of serious mental illness, serious psychological distress, major depressive episodes, symptoms of depression, and suicidal ideation data suggest the importance of focusing on depression and suicidal ideation, specifically among those that are under 25 years of age.

Intervening Variables (Risk/Protective Factors) (2-5 years)

Why here?

The Consortium reflected on, "Why are these problems present in our state?" and further identified key short-term outcomes, also known as *intervening variables, or risk/protective factors.* We focused on key state-level intervening variables, recognizing that each county, tribe, and community will need to further identify their own local conditions.

Below is the list of the identified intervening variables for each behavioral health problem area listed above:

| Problem<br>Areas<br>(5-10 years)     | Intervening Variables<br>(Risk/Protective Factors) (2-5 years)  |
|--------------------------------------|---|
| Adult<br>Alcohol<br>misuse/<br>abuse | <ul> <li>Community norms</li> <li>Sense of connectedness to community</li> <li>Favorable Attitudes: Perception of harm (e.g., perception of benefits of limited use/moderation)</li> <li>Promotion of alcohol</li> <li>Availability</li> <li>Enforcement</li> <li>Traumatic childhood experiences (e.g., at the time of traumatic experience and retrospectively from adulthood)</li> </ul> |
| Underage<br>Drinking                 | <ul> <li>Access to alcohol</li> <li>Availability of alcohol</li> <li>Policies</li> <li>Promotion of alcohol</li> <li>Community norms</li> <li>Enforcement (e.g., lack of enforcement and perception of lack of enforcement)</li> <li>Traumatic childhood experiences (e.g., at the time of traumatic experience and retrospectively from adulthood)</li> </ul>                              |
| Marijuana<br>misuse/<br>abuse        | <ul> <li>Availability</li> <li>Favorable Attitudes: Perception of harm</li> <li>Enforcement (e.g., inconsistent application of laws in light of de-emphasis)</li> <li>Adults who use</li> <li>Laws (e.g., confusion about laws)</li> <li>Traumatic childhood experiences (e.g., at the time of traumatic experience and retrospectively from adulthood)</li> </ul>                          |

| Problem<br>Areas<br>(5-10 years)          | Intervening Variables<br>(Risk/Protective Factors) (2-5 years)  |
|---|---|
| Prescription<br>Drugs<br>misuse/<br>abuse | <ul> <li>Availability (e.g., over prescribing, unused medication, and 'doctor shopping')</li> <li>Supply (e.g., abundant supply of prescription drugs)</li> <li>Favorable Attitudes: Perception of harm ( e.g., misuse of prescribed and non-prescribed drugs and improper use of medications)</li> <li>Enforcement (e.g., unclear under the influence laws)</li> <li>Community norms</li> </ul>  |
|   | Traumatic childhood experiences (e.g., at the time of traumatic experience and retrospectively from adulthood)  |
| Tobacco<br>misuse/<br>abuse               | <ul> <li>Policies (e.g., inconsistent policies and enforcement of policies in schools)</li> <li>Laws (e.g., preemption and local laws)</li> <li>Access (e.g., hookah lounges)</li> <li>Promotion of tobacco (e.g., targeted advertising to low-income/minority populations)</li> <li>Favorable Attitudes: Perception of harm</li> <li>Traumatic childhood experiences (e.g., at the time of traumatic experience and retrospectively from adulthood)</li> </ul> |
| Depression                                | <ul> <li>Community norms (e.g., stigma of MH screenings, MH screening not part of routine health screening, and community awareness and knowledge regarding treatability)</li> <li>Perception of stigma</li> <li>Connection to other mental health disorders (e.g., anxiety)</li> <li>Traumatic childhood experiences (e.g., at the time of traumatic experience and retrospectively from adulthood)</li> </ul>   |
| Suicide<br>Ideation                       | <ul> <li>Teens and young adults suicidal ideation</li> <li>Connection to other mental health disorders</li> <li>Traumatic childhood experiences (e.g., at the time of traumatic experience and retrospectively from adulthood)</li> </ul>   |

Following a review of each of these problem areas, we identified six common **intervening variables**, to address: 1) Access, 2) Availability, 3) Favorable Attitudes: Perception of harm, 4) Enforcement, 5) Community norms, and 6) Policies. These intervening variables were then used as the basis for our development of strategies later in our planning.

#### **Resources Assessment**

For our second assessment, we compiled information on state-level resources provided by the Consortium partners. The goal of the Resources Assessment Workgroup was *"to gather STATE-LEVEL resources that support substance abuse prevention and mental health promotion, in order to inform our strategic planning as well as identify where our resources are linked and where gaps are present."* We discussed the information to be collected and the level of analysis to be conducted on information gathered, in order to inform our strategic planning. Using this information, we created a map of state-level programs that illustrates where services from various state agencies are being delivered and a matrix that identifies the targeted problems addressed and the strategies being used.

The SPE Resources Assessment Workgroup included partners from Department of Commerce, Community Mobilizing Program; Department of Health, Division of Prevention and Community Health; Department of Health and Social Services, Division of Behavioral Health and Recovery; and the Office of the Attorney General.

Using the same **problem areas**, established in the data assessment, the workgroup established elements of the resources assessment within two categories to include, *Agency/Organization Information* (sources of funding received at the state-level, funding allocation from the state agencies to county/regional/local sites, training information, and data collection information); and *Resources Information* (name of resources, location of local allocation of resources for mapping, primary problem addressed, other areas of focus, target populations (age, race, and ethnicity), strategies used by resource and data related to their planning and monitoring).

For the purposes of this assessment, 'state-level' includes resources funded through state, federal and tribal sources within our state. 'Resource' is a strategy, program, policy, initiative, and/or service provided by the agency/organization.

#### Key Findings:

Resource information was collected via an online survey and through interviews. In 2015 eighteen (18) agencies/organizations participated in the survey and over sixty-five (65) resources were identified that directly or indirectly address substance abuse prevention/mental health promotion. Resource focuses in 2015 did not significantly change from resources in 2011. Detailed information from the resources assessment and comparison charts from 2011 to 2015 can be found in Appendix - beginning on page 100. Below is a summary of key information analyzed<sup>7</sup>.

Most common focus areas being addressed (2015)

- General Substance Abuse (65%)
- Drinking and Driving (34%)
- Adverse Childhood Experiences (35%)
- General Mental Health (38%)
- Other Illicit Drugs (45%)
- Family relationships (40%)

<sup>&</sup>lt;sup>7</sup> Resources may be duplicated as agencies were allowed to select more than one area, therefore category totals will equal more than 100 percent if combined.

Relative to addressing substance abuse, the chart to the right shows the percentage and the number of resources by substance.

Most common strategies (2015):

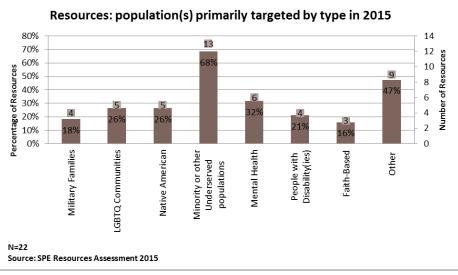
- Policy/Community Norms (42%)
- Cross-system Planning/ Collaboration (39%)
- Education (youth education/skill building; parent education/family support; other educational programs) (105%)\*
- Community Engagement/Coalition Development (32%)
- Information Dissemination (32%)
- Problem Identification & Referral (23%)

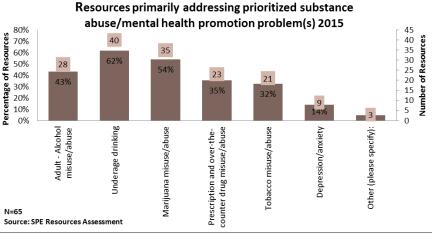
#### Target Populations (2015):

- While we have broad coverage on all ages, these resources most often focus on *adolescents*, young adults and adults.
- Minority or other underserved populations (68%) was the most common specific population targeted followed by

Native American/Tribes (26%), LGBTQ (26%), and Mental Health (20%)

The chart to the right shows the percentage and number of 2015 resources targeting specific populations.





<u>Services by Location</u> (Full size maps and acrnoym list are available in Appendix – Maps, page 102.)

We have broad distribution of prevention services across the state. Below is a map illustrating the prevention programs by state agency/organization where local location was available in 2013. This section was not updated in the 2015 Strategic Plan Update.



In 2013 there were over 169 coalitions working at the local level to support coordinated prevention and promotion efforts.



#### Prevention activities supported by coordinated funding streams

There are a number of prevention activities<sup>8</sup> that are supported by state-level coordinated funding streams both directly and indirectly. In 2012 had a total of 43 prevention activities supported by coordinated funding streams, and we anticipate that by 2017, we will have 65.

Beginning in October 2011, as part of this State Prevention Enhancement grant, the Consortium began working on four (4) specific prevention projects with coordinated funding. Prior to the start of this grant we had multiple projects supported by coordinated funding including the State Prevention Summit conference, Spring Youth Forum conference, four Reducing Underage Drinking strategies, Healthy Youth Survey, CORE GIS data collection and analysis, College Coalition, and Community Prevention and Wellness Initiative. As part of the state Community Prevention and Wellness Initiative. As part of the state Community Prevention and Wellness Initiative, some of the Consortium partners have been involved in this process to support local coalitions. In 2012 we supported 34 local prevention activities (local coalitions) that include coordinated funds from Division of Behavioral Health and Recovery and Office of the Superintendent of Public Instruction, which were paired in many cases with Department of Health Community Transformation grant neighborhoods, Community Mobilization coalitions and Drug-Free Communities coalitions. Where possible, we looked to facilitate cross-agency communication to support aligning their local work in these areas when it fits the needs of the communities.

#### 2015 Update:

Since October 2011 the prevention activities supported by state level coordinated funding has somewhat expanded. Continued state-wide prevention activities include the State Prevention Summit conference, Spring Youth Forum conference, Washington Healthy Youth Coalition (formally RUaD) communication and policy strategies, Healthy Youth Survey, CORE GIS data collection and analysis, College Coalition and CPWI (formerly PRI). In addition, other additional prevention activities have occurred such as, the expansion of SBIRT services, Washington State Prescription Drug Monitoring Program, youth marijuana use prevention campaigns, Alcohol & Drug Abuse Institute (ADAI) surveillance, and Evidence Based Practices development.

The CPWI efforts have expanded and now support 54 communities in local prevention coalitions and school partnerships. Additionally, five (5) new communities will join CPWI in 2015-2016 with the support of additional youth marijuana use prevention funding.

#### Analysis and Prioritization of Resources:

In conclusion, following a comprehensive review of this information, the Resources Assessment suggests continued support for what we have in place, that we build on current partnerships, and we look to establish new collaborative strategies and activities to work on together as the Consortium. As will be shown in the following section, this information was instrumental in informing our strategic planning, particularly in the development of strategies that address **intervening variables**, shown to impact our established outcomes.

<sup>&</sup>lt;sup>8</sup> Note: "Prevention activity" in this instance is specifically defined by SAMHSA as any policies, programs, or practices implemented by the Consortium to address the [SPE grant] goals. When funds from multiple programs are used to finance an activity, that activity is said to be supported by coordinated funding streams.

### Section 4: Plan for Action (Goals, Objectives, and Strategies)

Subsequent to the completion of our assessments of state substance use and mental health disorders data and resources we began to discuss and confirm our plan for working together to meet our common goals. This section details the discussions and decisions leading to the Consortium's commitment to support existing programs and partnerships and building collaborative strategies focused on public campaigns, policies and professional development to address our problem areas. The Consortium developed strategies that will make the most of the unique role of a state-level coalition to contribute to broad-based impact.

#### Common goals, objectives, and strategies for coordinating services

As the Consortium considered the recommendations and conclusions provided by the assessments, we also considered the question of, "What are we trying to build?" We agreed the goal of the Consortium is to build the health and wellness of individuals, families, schools, and communities where people can be as healthy as possible in a safe and nurturing environment.



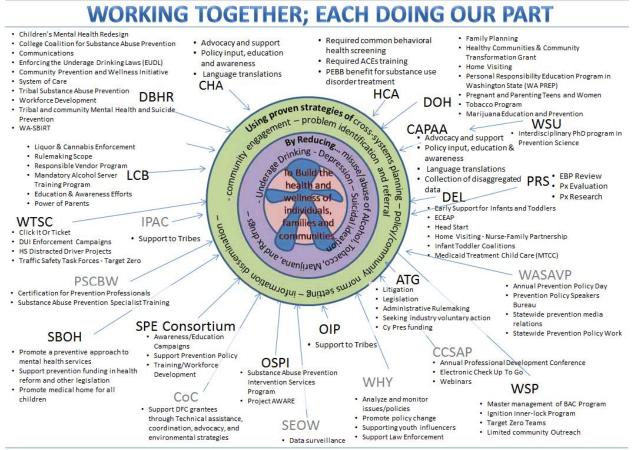
What are we doing about it? As mentioned previously, a key value of the Consortium is to honor and support the current efforts of each of the partners. Using the information from our Resources Assessment, we were able to review our current state-level supports for substance abuse prevention and mental health promotion, and to identify key opportunities to coordinate our services and efforts.

The following six primary strategies were identified as a result of the review of current work and as an opportunity for alignment to support our goal to build the health and wellness of individuals, families and communities in Washington State:

| Strategy                                       | Number of<br>agencies/organizations<br>providing a resource in<br>this strategy | Number of resources<br>directly or indirectly<br>using this strategy |
|--|---|--|
| Cross-systems Planning/Collaboration:          | 11  | 24   |
| Policy/Community norms:                        | 9   | 26   |
| Education:                                     | 11  | 65   |
| Community Engagement/Coalition<br>Development: | 11  | 20   |
| Information Dissemination:                     | 9   | 20   |
| Problem Identification and Referral:           | 5   | 14   |

Based on our Resources Assessment, we were able to identify a total of 1,935 local prevention activities<sup>9</sup> that are supported by the Consortium partners. An essential component of coordinated services is clear awareness and understanding of the various elements of state services and how they are delivered. The Consortium has agreed to refine and update this resource information annually to ensure that we are able to keep abreast of state-level resources and coordinate service where applicable and appropriate.

Below is an illustration of the state level agencies and organizations and their specific programs/initiatives that focus on substance abuse prevention and mental health promotion. For a full page diagram see Appendix - *Diagram of Resources* page 105.



This diagram shows the state-level agencies/organizations and their specific programs that focus on substance abuse prevention and mental health promotion. As of July 2015

In our assessment we reached beyond the traditional substance abuse prevention-focused agencies to include agencies and organizations that will assist in building connections for primary care and behavioral health integration efforts for example, the State Board of Health and the Health Care Authority. These two state entities play a fundamental role in partnering with the agencies that have primary care as their principal focus.

<sup>&</sup>lt;sup>9</sup> *Note:* "Prevention activity" in this instance is specifically is defined by SAMHSA as any policies, programs, or practices implemented by the Consortium to address the [SPE grant] goals. When funds from multiple programs are used to finance an activity, that activity is said to be supported by coordinated funding streams.

#### Strategic direction for strategies, activities, and policy initiatives

Furthermore, in addition to identifying current resources directed to support these efforts, the Consortium also identified significant partnerships and opportunities for collaborative projects within these identified strategies.

# Partnerships: Prevention activities and policies supported by partnerships among Consortium agencies

These opportunities were identified for specific partnership that will further our efforts:

- Supporting continued work by the Washington State Healthy Youth State (WHY) Coalition regarding policy and education campaigns focused on reducing underage drinking.
- Enabling cross-agency communication to support Washington State Patrol and Washington Association of Sheriffs and Police Chiefs (WASPC) in enforcement of the new law that states that during DUI enforcement, if someone under 16 years of age is in the vehicle and if there is a family relationship, law enforcement is required to immediately notify Child Protective Services.
- Facilitate and coordinate the multiple efforts to support local community coalitions, such as Drug Free Communities (DFC) grantees, Community Prevention and Wellness Initiative (CPWI) coalitions, Community Mobilization coalitions, and Community Transformation Grant (CTG) neighborhoods.
- Partner with groups that are working on prescription drug monitoring systems to coordinate efforts and monitor effectiveness.
- Continue the cross-agency collaboration supporting the implementation of the Healthy Youth Survey, as well as the effective use of the results.
- Partner with tribal programs and initiatives, such as the Northwest Tribes Task Force, which focuses on tribal laws and policies regarding prescription drug abuse.
- Continue partnership to support a searchable online resource for substance abuse prevention evidence-based list.
- Continued partnerships for data sharing and consideration for improvements to analysis and reporting of multiple data across multiple systems.
- Continue to provide opportunities for all partner agencies to participate in the organization and implementation of statewide training opportunities, including the Prevention Summit and the Youth Forum.

#### SPE Consortium Collaborative Strategies

# What are we doing about it together?

coordinated resources In addition to the direct services being offered by all of the partnering agencies and

Collaborative Strategies: Prevention activities and policies supported by

In addition to the direct services being offered by all of the partnering agencies and organizations as noted previously, and in order to capitalize on the unique role of the Consortium, we are focused on three main collaborative strategies:

- Policy review, advocacy, and promotion that is focused on the problem areas.
- Education/Workforce Development which includes professional development for providers across all healthcare and prevention systems.
- Information Dissemination/Public Awareness to include public media, education, and or awareness campaigns focused on policies and community norms that are specific to the problem area being addressed.

Beginning in September through December 2012, and annually thereafter, the Consortium engaged in rich discussions to further discern and elaborate on specific Action Plans related to the public campaigns, policy efforts, and professional development needed for each respective problem area (underage drinking; misuse/abuse of adult alcohol, marijuana, tobacco, and prescription drugs; depression; and suicide ideation). Annually we review and update the Action Plans as needed to make sure we are meeting our goals.

#### Action Plan Strategies by Behavioral Health Problem – updated 2015

#### Young Adults & Pregnant Women Alcohol and Marijuana Misuse/Abuse Prevention (updated 2015) *Workgroup Team:* Work with existing College Coalition and Screening, Brief Intervention, and Referral to Treatment (SBIRT) program to implement SPE strategies.

- *Policy:* Develop method for collecting statewide data on young adults for both those attending college and not attending college.
- **Policy:** Promote the use of SBIRT/BASICS among universities and colleges and 2) promote the use of SBIRT/BASICS for use with pregnant women.
- *Policy:* Improve care for young adults based on analysis of Young Adult Survey.
- **Policy:** Expand use of SBIRT program to be used to reach youth in public school settings.
- *Education/Professional Development Strategy:* Provide training and technical assistance to healthcare clinics to screen for tobacco use and refer to cessation resources.
- Information Dissemination/Public Awareness: Host or join a conference to teach about implementation of SBIRT.

#### Underage Drinking and Youth Marijuana Use Prevention (updated 2015)

*Workgroup Team:* Maintain integration with the state Washington Healthy Youth Coalition (WHY) to support the established priorities which include: Analyze and Monitor Issues/Policies; Promote Policy Change; Supporting Youth Influencers; and Support Law Enforcement.

• **Policy:** As appropriate, promote public or corporate policy changes with respect to emerging issues related to underage drinking and underage marijuana use.

- **Policy**: As appropriate, promote legislation, rule-making and other regulatory action related to prevention and reduction of underage drinking and underage marijuana use.
- *Policy:* Engage state agencies, community partners, and local providers to monitor impacts of marijuana legislation on state and communities.
- *Policy:* Advocate for prevention best practices with Liquor Cannabis Board in rule making for marijuana industry.
- Information Dissemination/Public Awareness: Analyze and disseminate information respect to emerging issues related to underage drinking and underage marijuana use.
- Information Dissemination/Public Awareness: Support community, regional, and statewide partners in distributing messaging for expanded underage drinking / youth marijuana use prevention toolkit.
- Information Dissemination/Public Awareness: Inform legislators and public officials of salient issues and developments relating to underage drinking and marijuana use through regular meetings with the Healthy Youth Coalition.
- Information Dissemination/Public Awareness: Use the Results Washington (A3) Process to inform public officials of salient issues and developments relating to underage drinking and marijuana use.
- Information Dissemination/Public Awareness: Support community, regional, and statewide partners in distributing messaging.
- Information Dissemination/Public Awareness: Communications campaign to educate the public regarding marijuana risks, resources, and understanding the new law pursuant to passage of Initiative 502 legalizing adult-use marijuana and disseminate via schools, community coalitions and networks, public health, and law enforcement.
- Information Dissemination/Public Awareness: Expand target audience for Website Resources and FAQs.

## Tobacco Misuse/Abuse Prevention (updated 2015)

Workgroup Team: Maintain State Inter-agency workgroup to focus on SPE strategies.

- *Policy:* Provide education and information on the creation of no-smoking policies to create smoke-free workplaces specifically targeting college and state agencies.
- *Policy:* Increase tobacco prevention funding by providing information to policy makers on the impacts of prevention.
- *Policy:* Reduce Youth Access to Tobacco by increasing the minimum legal sales age.
- *Policy:* Reduce depictions of tobacco use in youth-rated movies.
- *Policy:* Reduce youth access to vapor products.
- *Education/Workforce development:* Provide training and technical assistance to healthcare clinics to screen for tobacco use and refer to cessation resources in order to increase number of patients screened.
- Information Dissemination/Public Awareness: Establish and maintain public awareness of the causal link between smoking in movies and youth smoking.
- Information Dissemination/Public Awareness: Promote opportunities and resources that already exist with local community coalitions, law enforcement, health care providers, patients and patient advocates, Tribal entities, and public/individuals at risk.

- Information Dissemination/Public Awareness: Promote and update the website. Resources for questions about secondhand smoke to the website www.smokefreewashington.com and publicize the site in their respective organizations' materials.
- Information Dissemination/Public Awareness: Engaging existing coalitions to include tobacco prevention activities and mobilize the communities in the state against youth tobacco use.

#### Prescription Drug Misuse/Abuse and Overdose Prevention (updated 2015)

*Workgroup Team:* Maintain statewide workgroup to implement SPE strategies. Work collaboratively with existing statewide Unintentional Poisoning Workgroup and Information Dissemination committee.

- *Policy:* Identify funding sources for a broad scale social marketing campaign on prescription opiates and pain relief norms.
- **Policy:** Increase available funding by support funding requests and grant applications related to Rx Prevention projects and initiatives.
- *Education/Workforce Development:* Educate health care providers on revised Agency Medical Directors' Group (AMDG) *Interagency Guideline for Prescribing Opioids for Pain* to ensure appropriate opioid prescribing.
- *Education/Workforce Development:* Promote the use of the Prescription Drug Monitoring Program (PMP) among healthcare providers to help identify opioid use patterns, sedative co-prescribing, and indicators of poorly coordinated care/access.
- *Education/Workforce Development:* Promote accurate and consistent messaging about opioid safety and addiction by public health, law enforcement, community coalitions and others.
- *Education/Workforce Development:* Educate patients and the public on the importance and methods of proper storage and disposal of prescription pain medication.
- Information Dissemination/Public Awareness: Conduct an inventory of existing patient materials on medication safety for families and children. Develop new materials as needed as tools for medical providers and parents.
- Information Dissemination/Public Awareness: Develop materials to clarify best practices and correct misconceptions about disposal.

#### Mental Health Promotion, Depression & Suicide Ideation Prevention (updated 2015)

*Workgroup Team:* Re-establish a statewide workgroup involving Suicide Prevention Steering Committee and Project Aware Grant to implement SPE strategies. Identify strategies to implement from ESHB2315 State Suicide Prevention Plan.

- *Education/Workforce Development:* Enhance coordination, planning and activities between multiple child serving and intervention agencies and groups addressing suicide prevention.
- *Education/Workforce Development:* Provide/ support training to enhance workforce knowledge of Youth Mental Health First Aid response in high-need communities.
- Information Dissemination/Public Awareness: Collect data and resources to provide to communities including 1) Prevention and intervention material to reduce potential for youth suicide and depression and 2) Response (Post-intervention) to communities experiencing crisis of multiple suicides/contagion.
- Information Dissemination/Public Awareness: Increase Primary Care Provider's knowledge of role in suicide prevention. Support and disseminate information for PCP's in suicide prevention.

## **Section 5: Implementation**

In order to accomplish our goals, the Consortium is committed to continuing support for the current resources directed to these efforts, as well as opportunities for partnerships and collaborative projects within identified strategies. We will continue to review and update our strategies as needed.

#### Prevention activities and policies supported by Consortium Partners

As shown in the matrix below, the Consortium partners each play a role in providing direct or indirect substance abuse prevention and mental health promotion services.

| Agency – Resource<br>(List of Acronyms is available in the Appendix - <i>List of Agencies</i><br><i>Acronyms and Abbreviations</i> , page 53) | General Substance<br>Abuse | General Mental<br>Health Promotion | Adverse Childhood<br>Experiences | Crime/Delinquency | Violence | Primary Healthcare |
|---|----------------------------|------------------------------------|----------------------------------|-------------------|----------|--------------------|
| AGO - Litigation, Legislation, Administrative Rulemaking, And Seeking<br>Industry Voluntary Action  | х                          |                                    |                                  |                   |          |                    |
| CCSAP - Webinars  | х                          | х                                  |                                  |                   |          |                    |
| CCSAP - Year End Professional Development Conference  | х                          |                                    |                                  |                   |          |                    |
| CCSAP - Electronic Check Up to Go   | х                          | х                                  |                                  |                   |          |                    |
| DBHR - System of Care   | х                          | х                                  | х                                |                   | х        |                    |
| DBHR – Community Prevention and Wellness Initiative   | х                          | х                                  | х                                | х                 | х        | х                  |
| DBHR - Children's Mental Health Redesign  | х                          | х                                  | x                                |                   | х        | х                  |
| DBHR - Tribal Substance Abuse Prevention  | х                          | х                                  | x                                | х                 | х        | х                  |
| DBHR - Enforcing the Underage Drinking Laws (EUDL)  | х                          |                                    |                                  |                   |          |                    |
| DBHR - College Coalition For Substance Abuse Prevention   | х                          | х                                  | х                                | х                 | х        | х                  |
| DBHR - Workforce Development  | х                          | х                                  | х                                |                   |          |                    |
| DBHR - Communications   | х                          | х                                  | х                                | х                 | х        | х                  |
| DBHR - Prevention Research Subcommittee   | х                          |                                    | х                                | х                 | х        |                    |
| DEL - Infant Toddler Regions  |                            | х                                  | х                                |                   |          |                    |
| DEL - Home Visiting Programs  | х                          | х                                  | х                                |                   |          | х                  |
| DEL - Head Start  | х                          | х                                  | х                                |                   |          |                    |
| DEL - Early Support for Infants And Toddlers  | х                          | х                                  | х                                |                   |          | х                  |
| DEL - ECEAP- Early Childhood Education Economic Assistance Program<br>State Preschool   |                            | x                                  |                                  |                   |          |                    |
| DEL - Medicaid Treatment Child Care Program   | х                          | х                                  |                                  | х                 | х        | х                  |
| DOH - Tobacco Program   | х                          |                                    |                                  |                   |          |                    |
| DOH - Project Launch Grant*   |                            | х                                  | х                                |                   |          |                    |
| DOH - Home Visiting*  | х                          | х                                  | х                                | х                 |          | х                  |
| DOH - Early Childhood Comprehensive Systems Grant*  |                            | х                                  |                                  |                   |          |                    |
| DOH - Children With Special Health Care Needs*  |                            | х                                  |                                  |                   |          | х                  |

\* Not updated in 2015 Update.

| DOH - Personal Responsibility Education Program in Washington State       x  | Agency — Resource<br>(List of Acronyms is available in the Appendix - <i>List of Agencies</i><br>Acronyms and Abbreviations, page 53) | General Substance<br>Abuse | General Mental<br>Health Promotion | Adverse Childhood<br>Experiences | Crime/Delinquency | Violence | Primary Healthcare |
|--|---|----------------------------|------------------------------------|----------------------------------|-------------------|----------|--------------------|
| DOH - Coordinated School Health Program*       x       x       x       x       x         DOH - Healthy Communities & Community Transformation Grant*       x       x       x       x       x         DOH - Family Planning*       x       x       x       x       x       x       x         DOH - Family Planning*       x       x       x       x       x       x       x       x         DOH - Family Planning*       x  |   |                            |                                    | х                                |                   |          |                    |
| DOH - Healthy Communities & Community Transformation Grant*       x<   | DOH - Pregnant and Parenting Teens And Women*   |                            |                                    | x                                |                   | х        |                    |
| DOH - Family Planning*       x       x       x       x       x       x         OJJ - Juvenile Detention Alternatives Initiative*       x       x       x       x         HCA - Service       x       x       x       x       x         HCA - Required Common Behavioral Health Screening Guideline Across       x       x       x       x         HCA - Required Training on Adverse Childhood Experiences       x       x       x       x       x         HCA - Support Tribes       x       x       x       x       x       x       x         ICB - Support Tribes       x       x       x       x       x       x       x         LCB - Reponsible Vendor Program       x       x       x       x       x       x         LCB - Reponsible Vendor Program       x       x       x       x       x       x         LCB - Reponsible Vendor Program       x       x       x       x       x       x         LCB - Randatory Alcohol Server Training Program       x       x       x       x       x         LCB - Support Tribes       x       x       x       x       x       x         OIP - Support Tribes       x       <   | DOH - Coordinated School Health Program*  | х                          | х                                  |                                  |                   | х        |                    |
| OJJ - Juvenile Detention Alternatives Initiative*       ×       ×       ×         HCA - Service       x       ×       ×       ×         HCA - Required Common Behavioral Health Screening Guideline Across       x       x       x       x       ×         All Managed Care Organizations.       x       x       x       x       x       x       x         HCA - Required Training on Adverse Childhood Experiences       x       x       x       x       x       x         HCA - Support Tribes       x       x       x       x       x       x       x       x         LCB - Agency Initiatives       x       x       x       x       x       x       x       x         LCB - Required Fraining Corpe       x       x       x       x       x       x       x       x         LCB - Rulemaking Scope       x       x       x       x       x       x       x       x       x         LCB - Rulemaking Scope       x       x       x       x       x       x       x       x         LCB - Rulemaking Scope       x       x       x       x       x       x       x       x       x       x       x </td <td>DOH - Healthy Communities &amp; Community Transformation Grant*</td> <td>х</td> <td>х</td> <td>х</td> <td></td> <td></td> <td>х</td> | DOH - Healthy Communities & Community Transformation Grant*   | х                          | х                                  | х                                |                   |          | х                  |
| HCA - ServicexxHCA - Required Common Behavioral Health Screening Guideline Across<br>All Managed Care Organizations.XXXXXHCA - Required Training on Adverse Childhood ExperiencesxxxxXHCA - Required Training on Adverse Childhood ExperiencesxxxxXHCA - Suport TribesxxxxxxIPAC - Suport TribesxxxxxxICB - Required FarentsxxxxxICB - Required ScopexxxxxICB - Required ScopexxxxxICB - Required FarentsxxxxxICB - Required ScopexxxxxxICB - State Scope ScopexxxxxxICB - Substance Abuse Prevention Intervention Services ProgramxxxxPSCBW   | DOH - Family Planning*  | х                          | х                                  | х                                |                   | х        | х                  |
| HCA - Required Common Behavioral Health Screening Guideline Across<br>All Managed Care Organizations.xxxxxxHCA - Required Training on Adverse Childhood ExperiencesxxxxxxxHCA - PEBB Benefit for Substance Use Disorder TreatmentxxxxxxxIPAC - Support TribesxxxxxxxxLCB - Agency InitiativesxxxxxxxLCB - Iduor EnforcementxxxxxxLCB - Responsible Vendor ProgramxxxxxLCB - Bduattory Alcohol Server Training ProgramxxxxxLCB - Education and Awareness EffortsxxxxxxOIP - Support TribesxxxxxxxOSPI - Project AwarexxxxxxxPSCBW - Certification for Prevention ProfessionalsxxxxxxWHY- Analyze and Monitor Issues/PoliciesxxxxxxxWHY - Support Law EnforcementxxxxxxxxWHY - Support InfluencersxxxxxxxxWHY - Support InfluencersxxxxxxxxWHY - Analyze and Monitor Issues/Policiesx  | OJJ - Juvenile Detention Alternatives Initiative*   |                            |                                    |                                  | х                 |          |                    |
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| HCA - PEBB Benefit for Substance Use Disorder TreatmentxxxxxxxIPAC - Support TribesxxxxxxxxLCB - Agency InitiativesxxxxxxxLCB - Nower of ParentsxxxxxxLCB - Rulemaking ScopexxxxxxLCB - Responsible Vendor ProgramxxxxxLCB - Budatory Alcohol Server Training ProgramxxxxxLCB - Education and Awareness EffortsxxxxxOIP - Support TribesxxxxxxOSPI - Project AwarexxxxxxPSCBW - Certification for Prevention ProfessionalsxxxxxWHY - Analyze and Monitor Issues/PoliciesxxxxxWHY - Supporting Youth InfluencersxxxxxSEOW - Data SurveillancexxxxxWASAVP - Annual Prevention Policy DayxxxxxWASAVP - Statewide Prevention Policy Workxxxxx  |   | x                          | х                                  | х                                |                   |          | x                  |
| IPAC - Support TribesxxxxxxLCB - Agency Initiativesx   | HCA - Required Training on Adverse Childhood Experiences  | х                          | х                                  | х                                |                   |          | х                  |
| LCB - Agency Initiatives       x       v </td <td>HCA - PEBB Benefit for Substance Use Disorder Treatment</td> <td>х</td> <td></td> <td></td> <td></td> <td></td> <td></td>  | HCA - PEBB Benefit for Substance Use Disorder Treatment   | х                          |                                    |                                  |                   |          |                    |
| LCB - Power of ParentsxLCB - Liquor EnforcementxLCB - Rulemaking ScopexLCB - Responsible Vendor ProgramxLCB - Mandatory Alcohol Server Training ProgramxLCB - Education and Awareness EffortsxOIP - Support TribesxXXXOSPI - Project AwarexYXXYXXYX <trr>YXYX<td>IPAC - Support Tribes</td><td>х</td><td>х</td><td>х</td><td>х</td><td></td><td>х</td></trr>   | IPAC - Support Tribes   | х                          | х                                  | х                                | х                 |          | х                  |
| LCB - Liquor EnforcementxLCB - Rulemaking ScopexLCB - Responsible Vendor ProgramxLCB - Mandatory Alcohol Server Training ProgramxLCB - Education and Awareness EffortsxOIP - Support TribesxxOSPI - Substance Abuse Prevention Intervention Services ProgramxxSPI - Project AwarexxxPSCBW - Certification for Prevention ProfessionalsxxxWHY - Analyze and Monitor Issues/PoliciesxxxWHY - Support Law EnforcementxxxSEOW - Data SurveillancexxxWASAVP - Annual Prevention Policy DayxxxWASAVP - Statewide Prevention Policy WorkxxxXXxxx  | LCB - Agency Initiatives  | х                          |                                    |                                  |                   |          |                    |
| LCB - Rulemaking ScopexLCB - Responsible Vendor ProgramxLCB - Mandatory Alcohol Server Training ProgramxLCB - Education and Awareness EffortsxOIP - Support TribesxxNxxOSPI - Substance Abuse Prevention Intervention Services ProgramxxXxxxOSPI - Project AwarexxPSCBW - Certification for Prevention ProfessionalsxxXxxxPSCBW - Substance Abuse Prevention Systems TrainingxWHY - Analyze and Monitor Issues/PoliciesxWHY - Support Ing Youth InfluencersxXxxSEOW - Data SurveillancexXxxWASAVP - Annual Prevention Policy DayxXxxXx <t< td=""><td>LCB - Power of Parents</td><td>х</td><td></td><td></td><td></td><td></td><td></td></t<>   | LCB - Power of Parents  | х                          |                                    |                                  |                   |          |                    |
| LCB - Responsible Vendor ProgramxLCB - Mandatory Alcohol Server Training ProgramxLCB - Education and Awareness EffortsxOIP - Support TribesxxOIP - Support TribesxxOSPI - Substance Abuse Prevention Intervention Services ProgramxxXxxxPSCBW - Certification for Prevention ProfessionalsxxXxxxPSCBW - Substance Abuse Prevention Systems TrainingxxWHY- Analyze and Monitor Issues/PoliciesxxWHY - Support Law EnforcementxxSEOW - Data SurveillancexxWASAVP - Annual Prevention Policy DayxxXxxXxxXALANX<   | LCB - Liquor Enforcement  | х                          |                                    |                                  |                   |          |                    |
| LCB - Mandatory Alcohol Server Training Program×LCB - Education and Awareness EffortsxxxxxxOIP - Support TribesxxxxxxxxOSPI - Substance Abuse Prevention Intervention Services ProgramxxxxxxOSPI - Project AwarexxxxxxxxPSCBW - Certification for Prevention ProfessionalsxxxxxxxPSCBW - Substance Abuse Prevention Systems TrainingxxxxxxxWHY- Analyze and Monitor Issues/PoliciesxxxxxxxWHY - Support Law EnforcementxxxxxxxSEOW - Data SurveillancexxxxxxxWASAVP - Annual Prevention Policy Dayxxxxxx   | LCB - Rulemaking Scope  | х                          |                                    |                                  |                   |          |                    |
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| OIP - Support TribesxxxxxxxOSPI - Substance Abuse Prevention Intervention Services ProgramxxxxxxOSPI - Project AwarexxxxxxxxxPSCBW - Certification for Prevention ProfessionalsxxxxxxxxxPSCBW - Substance Abuse Prevention Systems TrainingxxxxxxxxWHY- Analyze and Monitor Issues/PoliciesxxxxxxxxWHY - Supporting Youth InfluencersxxxxxxxxWHY - Support Law EnforcementxxxxxxxxSEOW - Data SurveillancexxxxxxxxWASAVP - Annual Prevention Policy Dayxxxxxxx   | LCB - Mandatory Alcohol Server Training Program   | х                          |                                    |                                  |                   |          |                    |
| OSPI - Substance Abuse Prevention Intervention Services ProgramxxxxOSPI - Project AwarexxxxxPSCBW - Certification for Prevention ProfessionalsxxxxxxPSCBW - Substance Abuse Prevention Systems TrainingxxxxxxWHY- Analyze and Monitor Issues/PoliciesxxxxxxWHY - Supporting Youth InfluencersxxxxxxWHY - Support Law EnforcementxxxxxxSEOW - Data SurveillancexxxxxxWASAVP - Annual Prevention Policy DayxxxxxxWASAVP - Statewide Prevention Policy Workxxxxxx   | LCB - Education and Awareness Efforts   | х                          |                                    |                                  |                   |          |                    |
| OSPI - Project AwarexxxPSCBW - Certification for Prevention ProfessionalsxxxxxPSCBW - Substance Abuse Prevention Systems TrainingxxxxxWHY- Analyze and Monitor Issues/PoliciesxxxxxWHY - Promote Policy ChangexxxxxWHY - Supporting Youth InfluencersxxxxxWHY - Support Law EnforcementxxxxxSEOW - Data SurveillancexxxxxWASAVP - Annual Prevention Policy DayxxxxxWASAVP - Statewide Prevention Policy Workxxxxx  | OIP - Support Tribes  | х                          | х                                  | х                                | х                 |          | х                  |
| PSCBW - Certification for Prevention ProfessionalsxxxxxxPSCBW - Substance Abuse Prevention Systems TrainingxxxxxWHY- Analyze and Monitor Issues/PoliciesxxxxxWHY- Promote Policy ChangexxxxxWHY - Supporting Youth InfluencersxxxxxWHY - Support Law EnforcementxxxxxSEOW - Data SurveillancexxxxxCoC - Federal Drug Free Communities Support ProgramxxxxWASAVP - Annual Prevention Policy DayxxxxWASAVP - Statewide Prevention Policy Workxxxx  | OSPI - Substance Abuse Prevention Intervention Services Program   | x                          | х                                  | x                                |                   |          |                    |
| PSCBW - Substance Abuse Prevention Systems TrainingxWHY- Analyze and Monitor Issues/PoliciesxWHY- Promote Policy ChangexWHY - Supporting Youth InfluencersxWHY - Support Law EnforcementxSEOW - Data SurveillancexCoC - Federal Drug Free Communities Support ProgramxWASAVP - Annual Prevention Policy DayxXxXxXxXxXxXxXxXxXxXxXxXxXxXxXxXxXxXxXXX  | OSPI – Project Aware  |                            | х                                  | х                                |                   |          |                    |
| WHY- Analyze and Monitor Issues/PoliciesxWHY- Promote Policy ChangexWHY - Supporting Youth InfluencersxWHY - Support Law EnforcementxSEOW - Data SurveillancexXXXCoC - Federal Drug Free Communities Support ProgramxWASAVP - Annual Prevention Policy DayxXX<   | PSCBW - Certification for Prevention Professionals  | х                          | х                                  | х                                | х                 | х        |                    |
| WHY- Promote Policy ChangexWHY - Supporting Youth InfluencersxWHY - Support Law EnforcementxSEOW - Data SurveillancexxCoC - Federal Drug Free Communities Support ProgramxWASAVP - Annual Prevention Policy DayxxWASAVP - Statewide Prevention Policy Workxx   | PSCBW - Substance Abuse Prevention Systems Training   | х                          |                                    |                                  |                   |          |                    |
| WHY - Supporting Youth InfluencersxWHY - Support Law EnforcementxSEOW - Data SurveillancexxXxxCoC - Federal Drug Free Communities Support ProgramxWASAVP - Annual Prevention Policy DayxxXxxWASAVP - Statewide Prevention Policy Workxx  | WHY- Analyze and Monitor Issues/Policies  | х                          |                                    |                                  |                   |          |                    |
| WHY - Support Law EnforcementxSEOW - Data SurveillancexxxxCoC - Federal Drug Free Communities Support ProgramxxxWASAVP - Annual Prevention Policy DayxxxxWASAVP - Statewide Prevention Policy Workxxxx   | WHY- Promote Policy Change  | х                          |                                    |                                  |                   |          |                    |
| SEOW - Data SurveillancexxxxCoC - Federal Drug Free Communities Support ProgramxxxWASAVP - Annual Prevention Policy DayxxxxWASAVP - Statewide Prevention Policy Workxxxx   | WHY - Supporting Youth Influencers  | х                          |                                    |                                  |                   |          |                    |
| CoC - Federal Drug Free Communities Support ProgramxWASAVP - Annual Prevention Policy DayxxxWASAVP - Statewide Prevention Policy Workxxxx  | WHY - Support Law Enforcement   | х                          |                                    |                                  |                   |          |                    |
| WASAVP - Annual Prevention Policy DayxxxWASAVP - Statewide Prevention Policy Workxxxx  | SEOW - Data Surveillance  | х                          | х                                  | х                                | х                 |          |                    |
| WASAVP - Statewide Prevention Policy Work     x     x     x     x  | CoC - Federal Drug Free Communities Support Program   | х                          |                                    |                                  |                   |          |                    |
|  | WASAVP - Annual Prevention Policy Day   | x                          |                                    | х                                |                   | x        |                    |
| WASAVP - Statewide Prevention Medial Relations    x    x    x    x   | WASAVP - Statewide Prevention Policy Work   | х                          |                                    | х                                | х                 | x        |                    |
|  | WASAVP - Statewide Prevention Medial Relations  | х                          |                                    | x                                | х                 | х        |                    |

| Agency – Resource<br>(List of Acronyms is available in the Appendix - <i>List of Agencies</i><br>Acronyms and Abbreviations, page 53) | General Substance<br>Abuse | General Mental<br>Health Promotion | Adverse Childhood<br>Experiences | Crime/Delinquency | Violence | Primary Healthcare |
|---|----------------------------|------------------------------------|----------------------------------|-------------------|----------|--------------------|
| WASAVP - Prevention Policy Speakers Bureau  | x                          |                                    |                                  |                   | х        |                    |
| SBOH - Health Disparities Council Behavioral Health Advisory<br>Committee   | х                          | x                                  |                                  |                   |          |                    |
| SBOH - Support Prevention Funding in Health Reform and Other Legislation  | х                          |                                    |                                  |                   |          | x                  |
| SBOH - Promote Medical Home for All Children  | х                          | х                                  |                                  |                   |          |                    |
| SBOH - Promote A Preventive Approach to Mental Health Services  |                            |                                    |                                  |                   |          | х                  |
| WSP - Master Management of BAC Program  | х                          |                                    |                                  | х                 | х        |                    |
| WSP - Limited Community Outreach  | х                          |                                    |                                  | х                 | х        |                    |
| WSP - Ignition Inner-Lock Program   | х                          |                                    |                                  |                   |          |                    |
| WSP - Target Zero Teams   | х                          |                                    |                                  | х                 |          |                    |
| WSU - Interdisciplinary PhD Program in Prevention Science   | х                          | х                                  | х                                | х                 | х        |                    |
| WTSC - Click It or Ticket   | х                          |                                    |                                  |                   |          |                    |
| WTSC - HS Distracted Driver Projects  | х                          |                                    |                                  |                   |          |                    |
| WTSC - DUI Enforcement Campaigns  | х                          |                                    |                                  |                   |          |                    |
| WTSC - Traffic Safety Task Forces - Target Zero   | х                          |                                    |                                  |                   |          |                    |

The Consortium believes that by continuing support for services provided by each agency/organization, coupled with working collaboratively on state-level strategies, we will contribute to the overall collective impact.

## **Structural Support for Collaboration**

The Consortium partners decided to retain the Consortium as a coalition of state agencies and organizations that will support the implementation of the agreed upon collaborative strategies. The Consortium will meet regularly every other month as a full Consortium with committees meeting in the interim. All of the partnering agencies of the current Consortium have agreed to continue to participate on the Consortium. DBHR has committed to provide ongoing staff support for the Consortium.

Our leadership structure and working committees focus on in-depth analysis of our problem areas and action steps related to each given collaborative strategy. Each partner agency and organization has committed through a Memoranda of Understanding to support specific commitments and reporting requirements on action step(s) agreed upon in this Five-Year Strategic Plan.

In accordance with our plan, the next year will be focused on specific action steps related to the identified strategies: public campaigns, policy efforts, and professional development needed for each of the seven specified problem areas. In order to more fully develop explicit action plans for each of

the problem areas (alcohol, marijuana, tobacco, prescription drugs, depression and suicide ideation), we established a learning community structure to provide guidance on presentations and information to be prepared. Each Steering Committee was required to create and provide presentations on information such as, additional data, literature reviews that emphasize leverage points for meaningful action, expert panels to discuss issues in-depth, and action plans. Upon agreement on each action plan, an Action Plan Team was established to carry out the tasks. Each year we will review and update the Action Plans as needed to make sure we are meeting our goals. See *Appendix 6-* for a summary of the specific partners committed to contributing to working on each Action Plan.

Additionally, the Consortium will look to involve new partners based on strategic direction and projects within this plan. For example, we are interested in inviting the Department of Labor and Industries to participate in the development of the activities of our action plans related to workplace and employment. Lastly, we will seek youth involvement in our planning through our established youth leadership network.

## Implementation plan and a 5-year timeline

As stated above, in addition to the commitment from each of the Consortium partners to support and engage in the implementation of the identified strategies, we will also develop new partnerships when necessary to fully implement.

It is important to reiterate that, while we have made considerable effort to be inclusive and gather the best information available for our planning, we also recognize that this plan will be used as the foundation for ongoing planning as we move into the future. It is important that we continue to review, analyze, and update the strategies within this plan as needed to meet the most relevant needs of our time. Moreover, in the coming year we will spend considerable time to develop specific action plans for each of these strategies.

The table on the following pages is an overview of key tasks to be included in the Consortium Collaborative Strategies.

| Task   | Lead               |   | 2013 | 2014 | 2015 | 2016 |
|--|--------------------|---|------|------|------|------|
| Policy Consortium                              |                    |   |      |      |      |      |
| Consortium bi-monthly meetings                 | DBHR               | Х | Х    | Х    | Х    | Х    |
| Renew leadership positions biennially          | Consortium         | Х |      | Х    |      | Х    |
| Set evaluation targets for selected indicators | Consortium         | Х |      |      |      |      |
| Steering Committee meetings                    |                    | Х |      |      |      |      |
| Underage Drinking (WHY)                        | Steering Committee | Х |      |      |      |      |
| Alcohol  | Steering Committee | Х |      |      |      |      |

# **Implementation Plan Timeline**

| Task   | Lead                 | 2012 | 2013 | 2014 | 2015 | 2016 |
|--|----------------------|------|------|------|------|------|
| Marijuana  | Steering Committee   | Х    |      |      |      |      |
| Tobacco  | Steering Committee   | Х    |      |      |      |      |
| Prescription Drugs   | Steering Committee   | Х    |      |      |      |      |
| Depression   | Steering Committee   | Х    |      |      |      |      |
| Suicide Ideation   | Steering Committee   | Х    |      |      |      |      |
| Establish Action Plan Teams                                | Each Team            | Х    | Х    | Х    | Х    | Х    |
| Establish meeting schedules for<br>Action Plan Teams       | Each Team            | Х    | Х    | Х    | Х    | Х    |
| Biennial review of resources                               | Resources Assessment | Х    | Х    |      | Х    |      |
| assessment   | Workgroup/Consortium |      |      |      |      |      |
| Biennial review of data<br>assessment                      | SEOW/Consortium      | Х    | Х    |      | Х    |      |
| Public media, education, and or                            |                      |      |      |      |      |      |
| awareness campaigns  |                      |      |      |      |      |      |
| Identify emerging opportunities                            | Consortium           | Х    | Х    | Х    |      | Х    |
| Prioritize messages to be                                  | Consortium           | Х    |      |      |      |      |
| developed  |                      |      |      |      |      |      |
| Identify issues for 1 <sup>st</sup> campaign               | Consortium           | Х    |      |      |      |      |
| Develop detailed work plan for campaign                    | Action Plan Team     | Х    |      |      |      |      |
| Implement work plan for 1st campaign                       | Action Plan Team     | Х    | Х    | Х    |      |      |
| Develop message  | Action Plan Team     | Х    |      |      |      |      |
| Test message   | Action Plan Team     | Х    |      |      |      |      |
| Refine message   | Action Plan Team     | Х    |      |      |      |      |
| Establish method to<br>disseminate strategies              | Action Plan Team     |      | Х    |      |      |      |
| Disseminate message via state partners                     | Consortium           |      | Х    |      |      |      |
| Disseminate message via local<br>communities               | Consortium           |      | Х    |      |      |      |
| Develop detailed work plan for 2 <sup>nd</sup><br>campaign | Action Plan Team     |      | Х    |      |      |      |
| Implement work plan for 2 <sup>nd</sup><br>campaign        | Action Plan Team     |      |      | Х    | Х    |      |
| Develop detailed work plan for 3 <sup>rd</sup><br>campaign | Action Plan Team     |      |      | Х    |      |      |

#### Washington State Substance Abuse Prevention and Mental Health Promotion Five-Year Strategic Plan

| Task  | Lead                 | 2012 | 2013 | 2014 | 2015 | 2016 |
|---|----------------------|------|------|------|------|------|
| Implement work plan for 3 <sup>rd</sup>   | Action Plan Team     |      |      | Х    | Х    | Х    |
| campaign  |                      |      |      |      |      |      |
| Policy review, advocacy and   |                      |      |      |      |      |      |
| promotion   |                      |      |      |      |      |      |
| Identify emerging opportunities   | Consortium           | Х    | Х    | Х    | Х    | Х    |
| Develop action initiative for local coalitions to use for 1 <sup>st</sup> priority initiative | Action Plan Team     | Х    |      | Х    |      | Х    |
| Develop message   | Action Plan Team     | Х    |      | Х    |      | Х    |
| Test message  | Action Plan Team     | Х    |      | Х    |      | Х    |
| Refine message  | Action Plan Team     | Х    |      | Х    |      | Х    |
| Establish method to<br>Disseminate strategies   | Action Plan Team     |      | Х    |      | Х    |      |
| Disseminate message via state<br>partners   | Consortium           |      | Х    |      | Х    |      |
| Disseminate message via local<br>communities  | Consortium           |      | Х    |      | Х    |      |
| Develop detailed work plan for 2 <sup>nd</sup><br>initiative                                  | Action Plan Team     |      | Х    |      |      |      |
| Implement work plan for 2 <sup>nd</sup><br>initiative   | Action Plan Team     |      |      | Х    | Х    |      |
| Develop detailed work plan for 3 <sup>rd</sup> initiative                                     | Action Plan Team     |      |      | Х    |      |      |
| Implement work plan for 3 <sup>rd</sup><br>initiative   | Action Plan Team     |      |      | Х    | Х    | Х    |
| Review screening practices  | Steering Committee   | Х    |      | Х    |      | Х    |
| Determine effective methods<br>to integrate prevention into<br>screening                      | Action Plan Team     |      | Х    |      | Х    |      |
| Meet with primary care and<br>behavioral health care<br>providers                             | DOH, DBHR, HCA, SBOH |      | Х    |      | Х    |      |
| Develop understanding of<br>Medicaid among prevention<br>providers                            | HCA                  | Х    |      | Х    |      | Х    |
| Professional development across all   |                      |      |      |      |      |      |
| systems   |                      |      |      |      |      |      |
| Identify emerging opportunities   | Consortium           | Х    | Х    | Х    | Х    | Х    |

| Task  | Lead                           | 2012 | 2013 | 2014 | 2015 | 2016 |
|---|--------------------------------|------|------|------|------|------|
| Develop work plan for 'new<br>professional orientation'                                   | Action Plan Team               | Х    |      |      |      |      |
| Identify resources  | Action Plan Team               | Х    |      |      |      |      |
| Establish process   | Action Plan Team               | Х    |      |      |      |      |
| Create bureau of mentors  | Action Plan Team               |      | Х    |      |      |      |
| Provide mentorship  | Action Plan Team               |      | Х    | Х    | Х    | Х    |
| Determine training topics to be<br>included in cross systems training                     | Consortium                     | Х    | Х    | Х    | Х    | Х    |
| Identify host agency for training   | Action Plan Team               | Х    | Х    | Х    | Х    | Х    |
| Determine method for delivering training  | Action Plan Team               | Х    | Х    | Х    | Х    | Х    |
| Arrange logistics   | Action Plan Team               | Х    | Х    | Х    | Х    | Х    |
| Conduct training  | Action Plan Team               | Х    | Х    | Х    | Х    | Х    |
| Follow-up from training   | Action Plan Team               | Х    | Х    | Х    | Х    | Х    |
| Follow up from results of feasibility   |                                |      |      |      |      |      |
| studies   |                                |      |      |      |      |      |
| Prioritize timeframe for each study   | Consortium                     | Х    |      |      |      |      |
| Establish Teams to thoroughly review all findings and develop next steps                  | Consortium                     | Х    |      |      |      |      |
| Determine if new requirements<br>will be put into place and<br>timeframe for implementing | Consortium                     |      | Х    |      |      |      |
| If needed, develop work plan  | Consortium                     |      | Х    |      |      |      |
| If needed, establish Team to<br>implement work plan                                       | Consortium                     |      | Х    |      |      |      |
| Follow up from Primary Care<br>Demonstration Projects                                     |                                |      |      |      |      |      |
| Present at Consortium meeting   | Demonstration Project<br>sites | х    |      |      |      |      |
| Coordinate presentations to take place at state conference                                | DBHR                           | Х    |      |      |      |      |
| Integrate related information into DOH trainings  | DOH, DBHR                      | Х    |      |      |      |      |

| Task  | Lead                | 2012 | 2013 | 2014 | 2015 | 2016 |
|---|---------------------|------|------|------|------|------|
| Establish Team to thoroughly<br>review all findings and develop<br>next steps         | Consortium          | Х    |      |      |      |      |
| Determine if additional projects should be supported                                  | Consortium          |      | Х    |      |      |      |
| If so, develop work plan  | Action Plan Team    |      | Х    |      |      |      |
| If so, establish Team to<br>implement work plan                                       | Consortium          |      | Х    |      |      |      |
| Continue to examine integrating<br>data reporting systems with<br>additional partners |                     |      |      |      |      |      |
| Presentation at Consortium<br>meeting of various data systems                         | Consortium Partners | Х    |      |      |      |      |
| Determine if additional systems would be combined/connected                           | Consortium Partners | Х    |      |      |      |      |
| If so, develop work plan  | Action Plan Team    |      | Х    |      |      |      |
| If so, establish Team to<br>implement work plan                                       | Consortium          |      | Х    |      |      |      |

# **Plan for Cultural Competency**

The Consortium recognizes cultural competency as a key value, and we must be diligent in attending to it throughout all of our efforts. In order to be culturally competent, it is essential to understand the elements that lead to more fully inclusive and thoughtful planning and implementation.

The U.S. Department of Health and Human Services defines cultural competence as "a set of behaviors, attitudes, and policies that come together in a system, agency, or program or among individuals, enabling them to function effectively in diverse cultural interactions and similarities within, among, and between groups." Culture and language play a significant role in the design, delivery, accessibility, acceptability, and effectiveness of prevention services and activities. We know that both the Consortium and the individual members need to build on these competencies.

As individuals, we are committed to increasing our understanding of cultural competency and moving through cultural knowledge, awareness, and sensitivity to competence.<sup>10</sup> We also understand that cultural competence extends the concept of self-determination to the community. Cultural competence involves working in conjunction with natural, informal support and helping networks within culturally diverse communities (e.g., neighborhood, civic, and advocacy associations;

<sup>&</sup>lt;sup>10</sup> Community Anti-Drug Coalitions of America National Coalition Institute Cultural Competence Primer. 2007.

local/neighborhood merchants and alliance groups; ethnic, social, and religious organizations; and spiritual leaders and healers). <sup>11</sup>

As we know from the work done at the National Center for Cultural Competence, Georgetown University, building a culturally competent effort requires that organizations<sup>12</sup>:

- Have a defined set of values and principles, and demonstrate behaviors, attitudes, policies, and structures that enable them to work effectively cross-culturally.
- Have the capacity to (1) value diversity, (2) conduct self-assessment, (3) manage the dynamics
  of difference, (4) acquire and institutionalize cultural knowledge, and (5) adapt to diversity and
  the cultural contexts of the communities they serve.
- Incorporate the above in all aspects of policy making, administration, practice, and service delivery and involve systematically consumers, key stakeholders, and communities.

The Consortium will use tools<sup>13</sup>,<sup>14</sup> for ongoing assessment of our structure and support of membership, policies, structures, processes, and activities that include these critical components. We will conduct assessments regularly and make adjustments to effectively meet the needs of our state's population.

In 2015 we hosted a full day training opportunity focused on engaging communities to reduce health disparities in Washington State. Since 2013 we have hosted several presentations to inform and educate the Consortium membership. Such presentations include an overview of tobacco related health disparities report by the Department of Health, an overview of the services and needs addressed by the Commission on Hispanic Affairs, as well as sharing information and opportunities to participate in national webinars for priority populations including LGBTQ, Native Americans, Military Families and Veterans.

<sup>&</sup>lt;sup>11</sup> Adapted from Cross, T. et al, 1989

<sup>&</sup>lt;sup>12</sup> Adapted from - <u>http://nccc.georgetown.edu/foundations/frameworks.html</u>. Accessed June 2012.

<sup>&</sup>lt;sup>13</sup> "Promoting Cultural Diversity and Cultural Competency- Self Assessment Checklist for Personnel Providing Services and Supports to Children with Disabilities & Special Health Care Needs Goode, T., 2002, NCCC, GUCDC.

Click on <u>Resources and Tools</u> for checklists that reflect these values and principles in policy and practice. Accessed June 2012.

<sup>&</sup>lt;sup>14</sup> Taylor, T., & Brown, M., 1997, Georgetown University Child Development Center, (GUCDC) University Affiliated Program.

# **Section 6: Evaluation**

# Plan for tracking and reviewing evaluation information (baseline and outcomes data)

Based on our long-term commitment to collecting and reporting high quality data, Washington has an excellent data infrastructure, combining a management information system (MIS), a statewide youth survey, and a social indicator database that reports archival indicators at the school district level of geography. These systems are based on a theoretical framework that underpins substance abuse prevention.

The Consortium partners have a number of reporting systems that support our ability to compile data related to each level of analysis on our intended outcomes. A complete list of data sources used by Consortium partners is included in the *Appendix - Washington State Key Data Sources, page 58*. These data provide information on social impact indicators, as well as local community and service level data. Although, due to the complexities of the various funding allocation methods used by state agencies and the focus of services being delivered, we are not able to combine all service data collection systems, we currently have two state agencies committed to using a single system to collect service data from their respective providers. Furthermore, as one of our recent enhancements from the SPE grant projects, the Strategic Prevention Framework planning module has been added on the demo system of the prevention MIS. We will be able to begin testing and pre-loading data, and training staff and providers for full implementation of the new planning module with the start of the next fiscal year, July 2013. Regardless of which system is 'holding' the data, we have developed significant data-sharing agreements that allow for us to easily collect and compile valuable data not only for our assessments, but also to use in our evaluation.



So what? How will we know? The Consortium, under the guidance of the SEOW, selected the best measures available that provide points from which we can monitor our progress. This is not intended to be a finite list of all possible measures related to these issues. In January 2013, the Consortium finished an in-depth review of each of these indicators and set five-year targets for the **Intermediate Outcomes: Behavioral Health Problems**.

The tables on the following pages summarize the data indicators we will be monitoring over time related to our outcomes.

| Long-Term Outcomes: Consequences  | Source/ Year<br>Baseline <sup>15</sup>  |
|---|---|
| Chronic Disease   | DOH 2010  |
| <ul> <li>Alcohol related injury/accident (hospitalization)</li> </ul>   | Age 10-17: 12.8 per 100,000<br>Age 18-25: 83.8 per 100,000  |
| <ul> <li>Other drugs related injury/accident (hospitalization)<br/>under</li> </ul>   | Age 10-17: 56.9 per 100,000<br>Age 18-25: 195.2 per 100,000                                       |
| <ul> <li>Tobacco related deaths under age 10-17; 18-25</li> <li>Tobacco related injury/accident (hospitalization) under age 10-17; 18-25</li> </ul>     | N's are currently too small to<br>validate. We will continue to<br>monitor.                       |
| <ul> <li>Alcohol related deaths</li> </ul>  | Age 10-17: 3.7 per 100,000<br>Age 18-25: 19.1 per 100,000   |
| <ul> <li>Other drugs deaths</li> </ul>  | Age 10-17: 1.1 per 100,000<br>Age 18-25: 15.2 per 100,000   |
| Crime   | UCR 2010  |
| <ul> <li>For Arrests, Alcohol Violation Age 10-17</li> <li>For Arrests, Drug Violation 10-17</li> <li>For Arrests, Alcohol Related Age 18-24</li> </ul> | Rate of 4.8 per 1000<br>Rate of 4.8 per 1000<br>Rate of 25.8 per 1000                             |
| <ul> <li>For Arrests, Drug Related 18-24</li> </ul>   | Rate of 13.7 per 1000   |
| Low Graduation Rates  | OSPI 2009   |
| <ul> <li>HS Extended Graduation Rate (Includes On-Time)</li> </ul>  | 79%   |
| Suicide   | CHARS 2010  |
| <ul> <li>For Suicide and Attempts Age 10-17:</li> <li>For Suicide and Attempts Age 18-25:</li> </ul>  | Rate of 40.5 Per 100,000<br>Rate of 116.0 Per 100,000   |
| Fatalities and Serious Injury From Traffic Crashes  | WSDOT 2010  |
| <ul> <li># Alcohol-Related Traffic Injuries (Age 16-25)</li> </ul>  | Rate of .6 per 10,000 (16-17)<br>Rate of 1.8 per 10,000 (18-20)<br>Rate of 1.1 per 10,000 (21-25) |
| <ul> <li># Alcohol-Related Traffic Fatalities (Age 16-25)</li> </ul>  | Rate of .3 per 10,000 (16-17)<br>Rate of .5 per 10,000 (18-20)<br>Rate of .6 per 10,000 (21-25)   |

<sup>&</sup>lt;sup>15</sup> Technical notes related to each baseline indicator are maintained within original data source.

| Intermediate Outcomes:<br>Behavioral Health Problems                           | Source/ Year<br>2011 Plan Baseline <sup>16</sup> | 2013 Plan<br>Update | 2015 Plan<br>Update           | Original<br>2017<br>Target<br>10%<br>decrease<br>from<br>Baseline | Updated<br>2017<br>Target<br>10%<br>decrease<br>from HYS<br>2014 |
|--|--|---------------------|-------------------------------|---|--|
| Underage Drinking  | HYS 2010   | HYS 2012            | HYS 2014                      |   |  |
| <ul> <li>Drank Alcohol In Last 30<br/>Days*</li> </ul>                         | 10 <sup>th</sup> Grade: 27.7%                    | 23.3%               | 21.0%                         | 24.8%   | 19%  |
| <ul> <li>Experimental Use of<br/>Alcohol</li> </ul>                            | 10 <sup>th</sup> Grade: 10.9%                    | 8.5%                | 9.2%                          | 9.9%  | 8%   |
| <ul> <li>Ever drank Alcohol</li> </ul>   |  |                     | 6 <sup>th</sup> Grade:<br>21% |   | 19%  |
| <ul> <li>Heavy Use of Alcohol</li> </ul>                                       | 10 <sup>th</sup> Grade: 8.2%                     | 7.1%                | 5.8%                          | 7.2%  | 5%   |
| <ul> <li>Problem Drinking</li> </ul>   | 10 <sup>th</sup> Grade: 10.4%                    | 9.4%                | 6.9%                          | 9.0%  | 6%   |
| <ul> <li>Binge Drinking (any)</li> </ul>                                       | 10 <sup>th</sup> Grade: 16.2%                    | 14.3%               | 10.6%                         | 14.6%   | 10%  |
| Marijuana Misuse/Abuse   | HYS 2010   | HYS 2012            | HYS 2014                      |   |  |
| <ul> <li>Used Marijuana In Last 30<br/>Days*</li> </ul>                        | 10th Grade: 20.0%                                | 19.3%               | 18.1%                         | 18.0%   | 18%  |
| <ul> <li>Used Marijuana In Last 30<br/>Days*</li> </ul>                        |  |                     | 6 <sup>th</sup> Grade:<br>1%  |   | .99%   |
| <ul> <li>Used Marijuana 6+ Days</li> </ul>                                     | 10th Grade: 8.4%                                 | 8.6%                | 7.9%                          | 7.6%  | 7.6%   |
| Prescription Misuse/Abuse  | HYS 2010   | HYS 2012            | HYS 2014                      |   |  |
| <ul> <li>Used Pain Killer In Last 30<br/>Days*</li> </ul>                      | 10th Grade: 8.3%                                 | 6.0%                | 4.6%                          | 7.5%  | 4%   |
| <ul> <li>Used Ritalin-Type Drug In<br/>Last 30 Days</li> </ul>                 | 10th Grade: 3.5%                                 | 2.8%                |                               | 3.2%  |  |
| Tobacco Misuse/Abuse   | HYS 2010   | HYS 2012            | HYS 2014                      |   |  |
| <ul> <li>Smoked Cigarettes In Last<br/>30 Days*</li> </ul>                     | 10 <sup>th</sup> Grade: 12.7%                    | 9.5%                | 7.9%                          | 11.4%   | 7%   |
| <ul> <li>E-cigarettes / Vapor pens</li> </ul>                                  | 10 <sup>th</sup> Grade                           |                     | 18%                           |   | 16%  |
| <ul> <li>Any tobacco use<br/>(cigarettes and smokeless<br/>tobacco)</li> </ul> |  |                     | 6 <sup>th</sup> Grade:<br>2%  |   | 1.8%   |

<sup>\*</sup>Signifies primary target. <sup>16</sup> Technical notes related to each baseline indicator are maintained within original data source.

Washington State Substance Abuse Prevention and Mental Health Promotion Five-Year Strategic Plan

| Intermediate Outcomes:<br>Behavioral Health Problems                            | Source/ Year<br>2011 Plan Baseline <sup>17</sup> | 2013 Plan<br>Update | 2015 Plan<br>Update | Original<br>2017<br>Target<br>10%<br>decrease<br>from<br>Baseline | Updated<br>2017<br>Target<br>10%<br>decrease<br>from HYS<br>2014 <sup>18</sup> |
|---|--|---------------------|---------------------|---|--|
| Adult - Alcohol Misuse/Abuse  | BRFSS 2010                                       |                     |                     |   |  |
| <ul> <li>Women Report Alcohol<br/>Use any time During<br/>Pregnancy*</li> </ul> | 17.0%  |                     |                     | 15.3%   | 15%  |
| Depression  | HYS 2010   | HYS 2012            | HYS 2014            |   |  |
| <ul> <li>Sad/Hopeless In Past 12<br/>Months*</li> </ul>                         | 10th Grade: 29.8%                                | 30.9%               | 34.9%               | 26.8%   | 27%  |
| Suicide Ideation  | HYS 2010   | HYS 2012            | HYS 2014            |   |  |
| <ul> <li>Suicide Ideation*</li> </ul>   | 10th Grade: 17.6%                                | 18.8%               | 20.5%               | 15.8%   | 16%  |

<sup>\*</sup>Signifies primary target. <sup>17</sup> Technical notes related to each baseline indicator are maintained within original data source. <sup>18</sup> Red text indicates a new lower target percentage fro the original 2017 target.

| Short-term Outcomes:            | Source/ Year   |
|---------------------------------|--|
| Intervening Variables<br>Access | Baseline <sup>19</sup> HYS 2010• 10 <sup>th</sup> graders who got alcohol:- 7% bought it from a store- 18% gave money to someone to get it for them- 55% got it from friends or at a party- 27% home w/o permission• 10 <sup>th</sup> graders who ever used 'pain killers to get high':- 30% report using own prescription- 29% report getting it from a friendLCB 2010• 14,425 state licenses (rate of 2.15/1000 persons) [note: expect significant increase per I-1183]  |
| Availability                    | <ul> <li>HYS 2010</li> <li>10<sup>th</sup> graders: <ul> <li>56% report sort of or very easy to get alcohol</li> <li>54.4% report sort of or very easy to get marijuana</li> <li>52.7% report sort of or very easy to get cigarettes</li> </ul> </li> </ul>  |
| Community norms                 | <ul> <li>HYS 2010</li> <li>10<sup>th</sup> graders: <ul> <li>75.5% report that 'adults in the community think it's wrong or very wrong'</li> <li>70% saw 'anti-alcohol ads'</li> <li>55% parents talked about it</li> </ul> </li> <li>34.5 % of 10<sup>th</sup> graders report laws and norms favorable toward drug use</li> <li>8% of 10<sup>th</sup> graders report 'harassed due to health/disability'</li> </ul> <li>NSDUH 2008/ 2009 <ul> <li>17% of young adults (18-25 years) report marijuana use in past 30 days</li> </ul> </li> |
| Enforcement                     | <ul> <li>HYS 2010</li> <li>10<sup>th</sup> graders: <ul> <li>26% think the police would catch a kid drinking (response of 'yes' or 'YES!')</li> <li>31.2% think the police would catch smoking marijuana (response of 'yes' or 'YES!')</li> </ul> </li> </ul>  |
| Perception of harm              | <ul> <li>HYS 2010</li> <li>10th grade:</li> <li>27% think that there is no or slight risk to using marijuana regularly</li> </ul>  |

<sup>&</sup>lt;sup>19</sup> Technical notes related to each baseline indicator are maintained within original data source.

| Short-term Outcomes:  | Source/ Year   |
|-----------------------|--|
| Intervening Variables | Baseline <sup>19</sup>   |
| Policies              | <ul> <li>HYS 2010</li> <li>10<sup>th</sup> graders: <ul> <li>33.9% think school policies about alcohol and drugs are usually enforced (response of 'definitely yes')</li> <li>25.2% think 'no smoking policies' at school are usually enforced (response of 'definitely yes')</li> </ul> </li> </ul>   |
| Traumatic             | BRFSS 2010   |
| Experiences           | <ul> <li>ACE: Family Alcohol Use<br/>For those that live w/ anyone who has a problem drinker/alcoholic:</li> <li>20% Report Binge Drinking</li> <li>25% Report Smoking Cigarettes</li> </ul>   |
|                       | <ul> <li>ACE: Family Drug Use         For those that live w/ anyone who used illegal street drugs or who abused prescription medications:         <ul> <li>28% Binge Drinking</li> <li>33% Cigarettes</li> <li>18% Marijuana</li> <li>2% Pain Killer</li> </ul> </li> </ul>  |
|                       | <ul> <li>ACE: Family Mental Illness<br/>For those that live w/ anyone who was depressed, mentally ill, or<br/>suicidal:         <ul> <li>20% Binge Drinking</li> <li>22% Cigarettes</li> <li>12% Marijuana</li> </ul> </li> <li>ACE: Incarcerated Household Member<br/>For those that live w/ anyone who served time or was sentenced to<br/>serve time in a prison, jail, or other correctional facility:         <ul> <li>25% Binge Drinking</li> <li>38% Cigarettes</li> <li>21% Marijuana</li> <li>3% Pain Killer</li> </ul> </li> </ul> |
|                       | <ul> <li>Childhood Trauma – Source: RDA Report 11.178: Nov. 2012.</li> <li>1.7 = Average number of ACES for Medicaid youth age 12-17 (SFY 2008 data)</li> <li>28.3% = Percentage of the identified DSHS youth clients during state fiscal year (SFY) 2008 that had experienced 3 or more ACES</li> </ul>   |

The Consortium will continue to review these indicators regularly and update and revise as necessary to have the best measures in place. We will also monitor related indicators such as healthcare costs,

individual productivity, and employment outcomes; however, they are not included in the preceding tables due to the expected upcoming variance based on significant changes to overall healthcare systems. Furthermore, while we can gather data about college students biennially using the National College Health Association Health & Risk Behaviors Survey, there is a dearth of data about health/risk of young adults who are not attending college, except from police records. However, we are working to increase the data we have on young adults, including growing the number of young adults who complete the Behavioral Risk Factors Surveillance System to address this deficit. Consortium partners have also inquired with the national partners regarding the data collection on coalitions from the COMET and CADCA Survey to pull Washington State data. We will also continue examining ways for us to expand our ability to collect consistent state-level data on emerging issues, for example medical marijuana.

The State Epidemiological Outcomes Workgroup (SEOW) will continue to conduct surveillance on relevant outcome indicators and advise the Consortium of significant changes.

Additional measures will be determined to provide evaluation information as the action plans for specific problem area strategies are further developed.

## Required reporting for Substance Abuse Mental Health Services Administration (SAMHSA)

In addition to the evaluation efforts that support the specific long-, intermediate-, and short-term outcomes related to our strategies as shown in the logic model, we have set the following goals in coordination with the national Government Performance and Results Act (GPRA).

Below is a table showing the reporting elements baseline from state fiscal year 2011 and the projected five-year target. (Note: This was not assessed in the 2015 Update.)

| Measure   | Baseline<br>(State<br>FY11) | Target<br>(State<br>FY16) |
|---|-----------------------------|---------------------------|
| Percentage of communities <sup>20</sup> reporting data to the grantee system <sup>21</sup>                  | 90.6%                       | 100%                      |
| Percentage of communities submitting <u>process</u> data through grantee system. <sup>22</sup>              | 90.6%                       | 100%                      |
| Percentage of direct service providers submitting <u>process</u> data through grantee system. <sup>23</sup> | 9%                          | 12%                       |
| Percentage of communities submitting <u>outcome</u> data through grantee system <sup>23</sup>               | 54.7%                       | 66%                       |
| Percentage of direct service providers submitting <u>outcome</u> data through grantee system <sup>24</sup>  | 3%                          | 3.5%                      |

The Consortium will review outcome and process data annually to inform our evaluation and make adjustments as needed. Additionally, the Consortium will use this information to determine next steps for using this information including, how to inform partners, local organizations, and general public of pertinent data.

The Consortium continues to look forward to the implementation of this plan as an opportunity to infuse energy into our system as we enhance our capacity to support community level strategic prevention planning and service.

<sup>&</sup>lt;sup>20</sup> For the purposes of the required SAMHSA reporting, 'community' is being defined as, "Counties and Federally Recognized Tribes." Many of the Consortium partners contract with county governments and Federally Recognized Indian Nations. In some cases, two counties have a joint contract. In some cases, counties have opted not to accept funding, in which case a non-governmental or quasi-governmental agency is contracted with for services. Tribes have the option of spending funding on Prevention, Treatment, or both Prevention and Treatment.

 <sup>&</sup>lt;sup>21</sup> Method : Count of distinct DBHR counties and federally recognized tribes reporting in PBPS (the grantee system) in the specified state fiscal year 2011 (Excludes OSPI) Source: PBPS.
 <sup>22</sup> Method : Count of distinct DBHR counties and federally recognized tribes reporting in PBPS (the grantee system) in the specified state

<sup>&</sup>lt;sup>22</sup> Method : Count of distinct DBHR counties and federally recognized tribes reporting in PBPS (the grantee system) in the specified state fiscal year 2011 (Excludes OSPI) Source: PBPS.

<sup>&</sup>lt;sup>23</sup> Method : Count of distinct DBHR counties and federally recognized tribes reporting in PBPS (the grantee system) in the specified state fiscal year 2011 (Excludes OSPI) Source: PBPS. Count of service providers identified in the SPE Resource Assessment by the partner agencies. Source: SPE Resource Assessment map – statewide count

# Appendix

| <u>1.</u> | List of Agencies Acronyms and Abbreviations                           | . 53 |
|-----------|---|------|
| <u>2.</u> | SPE Consortium Partner List   | . 54 |
| <u>3.</u> | Brief Overview of Strategic Prevention Framework (SPF)                | . 55 |
| <u>4.</u> | Washington State Key Data Sources                                     | . 58 |
| <u>5.</u> | Data Assessment   | . 60 |
| <u>6.</u> | Learning Community Steering Committees1                               | 117  |
| <u>7.</u> | Logic Model – Updated 2015  | 118  |
| <u>8.</u> | Prevention Consortium Team Accomplishments 2013-2015                  | 119  |
| <u>9.</u> | Significant Events Influencing the Field of Prevention from 2011-2015 | 128  |
|           |   |      |

# APPENDIX

# 1. List of Agencies Acronyms and Abbreviations

- College Coalition for Substance Abuse Prevention (CCSAP)
- Department of Early Learning (DEL)
- Department of Health (DOH)
- Department of Social and Health Services (DSHS)
- Division of Behavioral Health and Recovery (DBHR)
- Frontiers of Innovation (FOI)
- Health Care Authority (HCA)
- Indian Policy Advisory Committee (IPAC)
- Liquor Control Board (LCB) Changed in 2015 to Liquor and Cannabis Board(LCB)
- Office of Indian Policy (OIP)
- Office of Juvenile Justice (OJJ)
- Office of Superintendent of Public Instruction (OSPI)
- Office of the Attorney General (AGO)
- Prevention Specialist Certification Board of Washington (PSCBW)
- State Board of Health (SBOH)
- State Epidemiological Outcome Workgroup (SEOW)
- Washington Association for Substance Abuse and Violence Prevention (WASAVP)
- Washington Drug Free Communities Coalition of Coalition
- Washington Healthy Youth Coalition (WHY)
- Washington National Guard (Nat'l Guard)
- Washington State Commission on Asian Pacific American Affairs (CAPAA)
- Washington State Commission on Hispanic Affairs (CHA)
- Washington State Institute for Public Policy (WSIPP)
- Washington State Patrol (WSP)
- Washington State Prevention Research Sub-Committee (Px Research Sub-Committee)
- Washington Traffic Safety Commission (WTSC)

# 2. SPE Consortium Partner List

| Partner Agency/Organization  | Policy Consortium Representative   |  |  |  |
|--|--|--|--|--|
| Commission on Asian Pacific American Affairs   | Michael Itti, Executive Director   |  |  |  |
| (CAPAA)  | Brianne Ramos, Project Coordinator   |  |  |  |
| College Coalition for Substance Abuse Prevention (CCSAP)   | Jason Kilmer, Research Assistant Professor and Asst. Director of Health/ Wellness, University of Washington  |  |  |  |
| Department of Early Learning (DEL)   | Veronica Santangelo, Medicaid Treatment Child Care Administrator   |  |  |  |
| Department of Health (DOH), Division of  | Consortium Co-chair David Hudson, Section Manager, Office of   |  |  |  |
| Prevention and Community Wellness  | Healthy Communities  |  |  |  |
|  | Cristal Connelly, Marijuana Prevention Education Coordinator<br>Frances Limtiaco, Tobacco Prevention Program Manager and Health<br>Equity Consultant   |  |  |  |
| Department of Social and Health Services (DSHS),<br>Division of Behavioral Health & Recovery (DBHR)  | Consortium Co-chair Sarah Mariani, Behavioral Health Administrator   |  |  |  |
| Department of Social and Health Services (DSHS),<br>Frontiers of Innovation (FOI)  | Anne Stone, State Director   |  |  |  |
| Department of Social and Health Services (DSHS),<br>Office of Indian Policy (OIP)  | Tim Collins, Director  |  |  |  |
| Department of Social and Health Services (DSHS),<br>Office of Juvenile Justice (OJJ)   | Currently Vacant   |  |  |  |
| Health Care Authority (HCA)  | Casey Zimmer, RN, Occupational Nurse Consultant  |  |  |  |
| Indian Policy Advisory Committee (IPAC)  | Currently Vacant   |  |  |  |
| Liquor Cannabis Board (LCB)  | Mary Segawa, Public Health Education Liaison   |  |  |  |
| Office of Superintendent of Public Instruction<br>(OSPI)   | Krissy Johnson, Program Supervisor, Student Assistance / Dropout<br>Prevention<br>Bill Evans, Program Consultant, Student Support Programs<br>Mandy Paradise, Project AWARE Program Supervisor |  |  |  |
| Office of the Attorney General (AGO)   | Currently Vacant (previously, Rusty Fallis, Assistant Attorney General)  |  |  |  |
| Prevention Specialist Certification Board of   | Liz Wilhelm, Education and Ethics Committee Chair  |  |  |  |
| Washington (PSCBW)   | Gunthild Sondhi, President   |  |  |  |
|  | Stephanie Brooks, Committee member   |  |  |  |
| State Board of Health (SBOH)   | Michelle Davis, Executive Director   |  |  |  |
| State Epidemiological Outcome Workgroup<br>(SEOW)  | Katie Weaver Randall, SEOW Co-chair; Evaluation and Quality<br>Assurance Administrator, DBHR   |  |  |  |
| Washington Association for Substance Abuse and Violence Prevention (WASAVP)  | Derek Franklin, President  |  |  |  |
| Washington Healthy Youth Coalition (WHY)   | Beatriz Mendez, EUDL Grant Coordinator, DBHR   |  |  |  |
| Washington State Commission on Hispanic<br>Affairs (CHA)   | Uriel Iñiguez, Executive Director  |  |  |  |
| Washington State Drug Free Communities<br>Coalition of Coalitions (CoC)  | Lisa Stewart, Mercer Island Communities that Care Coalition  |  |  |  |
| Washington State Institute for Public Policy<br>(WSIPP)  | Adam Darnell, Senior Research Associate  |  |  |  |
| Washington State Patrol (WSP)  | Lieutenant Dan L. Sharp  |  |  |  |
| Washington State Prevention Research Sub-  | Elizabeth Weybright, Associate Professor Dept. of Human  |  |  |  |
| Committee  | Development  |  |  |  |
| Washington Traffic Safety Commission (WTSC)  | Dick Doane, Research Investigator  |  |  |  |
| <ul> <li>Staff to Consortium provided by Division of Behavioral Health and Recovery (DBHR) 2014-present:</li> <li>Policy Consortium Lead Staff: Julia Havens, Prevention System Development Manager</li> </ul> |  |  |  |  |

- Policy Consortium Lead Staff: Julia Havens, Prevention System Development Manager
- Policy Consortium Support Staff: Lucilla Mendoza, Prevention System Manager

# 3. Brief Overview of Strategic Prevention Framework (SPF)

The Strategic Prevention Framework (SPF) was originally developed by the federal Substance Abuse and Mental Health Services Administration.<sup>24</sup> SAMSHA's Strategic Prevention Framework is a comprehensive planning process designed to help states and communities build the infrastructure necessary for effective and sustainable prevention. The Strategic Prevention Framework (SPF) uses a five-step process known to promote youth development, reduce risk-taking behaviors, build assets and resilience, and prevent problem behaviors across the life span. The SPF is built on a community-based risk and protective factors approach to prevention and a series of guiding principles that can be utilized at the federal, state/tribal and community levels.

The idea behind SPF is to use the findings from public health research along with evidence-based prevention programs to build capacity within states/tribes/territories and the prevention field. This in turn will promote resilience and decrease risk factors in individuals, families, and communities.

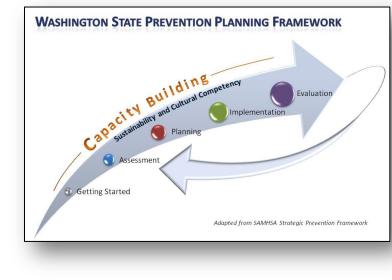
<u>The Strategic Prevention Framework Steps</u> require states, territories, federally recognized tribes and tribal organizations, and communities to systematically:

- Assess their prevention needs based on epidemiological data.
- Build their prevention capacity.
- Develop a strategic plan.
- Implement effective community prevention programs, policies and practices.
- Evaluate their efforts for outcomes.

Throughout all five steps, implementers of the SPF must address issues of sustainability and cultural competence.

The State Prevention Enhancement Policy Consortium used this overall planning framework for our process. Based on our learning from the Strategic Prevention Framework State Incentive Grant (SPF-SIG) process, for the purposes of prevention planning in Washington State, we have added a "Getting Started" section and have included "Capacity" as an ongoing step throughout the process. It is expected that all tasks will be conducted in a culturally competent manner.

The following is a brief description of each part of this process.



# **Cultural competence**

<sup>&</sup>lt;sup>24</sup> SAMHSA, 2011 - <u>http://www.samhsa.gov/prevention/spf.aspx</u>. Accessed July 2012.

The U.S. Department of Health and Human Services defines cultural competence as "a set of behaviors, attitudes, and policies that come together in a system, agency, or program or among individuals, enabling them to function effectively in diverse cultural interactions and similarities within, among, and between groups." Culture and language play a significant role in the design, delivery, accessibility, acceptability, and effectiveness of prevention services and activities.

Cultural competence requires that organizations<sup>25</sup>:

- Have a defined set of values and principles, and demonstrate behaviors, attitudes, policies, and structures that enable them to work effectively cross-culturally.
- Have the capacity to (1) value diversity, (2) conduct self-assessment, (3) manage the dynamics
  of difference, (4) acquire and institutionalize cultural knowledge, and (5) adapt to diversity and
  the cultural contexts of the communities they serve.
- Incorporate the above in all aspects of policy making, administration, practice, and service delivery and involve systematically consumers, key stakeholders and communities.

## **Sustainability**

Sustainability should include assets and resources that will promote and further the vision and mission of the coalition beyond the life of any given funding source. Examples of assets and resources include: policy changes, job descriptions, funding, use of facilities, and commitment from leadership, etc.

## **Getting Started**

Purpose: Initiate the process.

- Establish working Consortium.
- Set up basic structure of Consortium.

# Capacity: Mobilizing your state system and building capacity

**Purpose:** Developing and increasing state's capacity to support prevention and ability to address the problem(s).

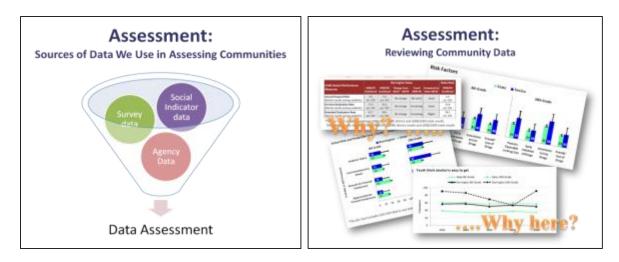
- Build effective Consortium.
- Clear roles and structure.
- Strategies for involvement of stakeholders and community.

## Assessment: Our state's needs, resources, readiness, & gaps

**Purpose:** Identify needs, resources, and gaps.

- Collect and analyze data.
- Identify people, scope, readiness and resources.
- Identify gaps of services for needs.

<sup>&</sup>lt;sup>25</sup> Adapted from - <u>http://nccc.georgetown.edu/foundations/frameworks.html</u>. Accessed July 2012.



## Planning: Develop a strategic prevention plan

**Purpose:** Create a plan for implementing and evaluating tested, effective programs, policies, and practices.

- Selection of programs, policies, and practices to fill gaps.
- Implementation and evaluation plans.
- Measurable outcomes.

## **Implementation: Implement evidence-based prevention strategies**

Purpose: Implement the plan.

- Confirm partnerships.
- Implement selected strategies, programs, policies, and practices.

#### Reporting and Evaluation: Evaluate and monitor results, change as necessary

Purpose: Evaluate the plan, and refine as needed.

- Evaluate the process and outcomes.
- Adjust the plan.

For more information about the Strategic Prevention Framework go to: http://www.samhsa.gov/prevention/spf.aspx.

# 4. Washington State Key Data Sources

In Washington State, we have a wealth of data from our key related collection systems including the following:

- <u>Community Outcomes and Risk Evaluation Geographic Information System (CORE GIS)</u> A comprehensive time-series collection of data related to substance use and abuse, and the risk factors that predict substance use among youth. <u>http://www.dshs.wa.gov/rda/research/risk.shtm</u>
- <u>Traffic Safety and Target Zero Teams Reports</u> These statistical mapping documents are generated on a 42-day rotational cycle and include information on collision, DUI arrests, other moving vehicle violations, and traffic fatalities.
- <u>Washington Traffic Safety Commission/Fatality Analysis Reporting System (FARS)</u> Data on fatal crashes in Washington including traffic crash reports, state driver licensing and vehicle registration files, death certificates, toxicology reports, and emergency medical services. Data is available by age of driver, BAC level, and all drug findings. http://www.wtsc.wa.gov/statistics-reports/about-our-data/
- Healthy Youth Survey (HYS)/AskHYS.net The information from the HYS can be used to identify trends in the patterns of behavior over time. In October 2002, 2004, 2006, 2008, 2010, 2014, students in grades 6, 8, 10, and 12 answered questions about safety and violence; physical activity and diet; alcohol, tobacco, and other drug use; and related risk and protective factors. <u>http://www.askhys.net/</u>
- <u>Behavioral Risk Factor Surveillance System (BRFSS)</u> This on-going telephone health survey system tracks health conditions and risk behaviors in the United States yearly since 1984. <u>http://www.cdc.gov/brfss/</u>
- <u>Performance Based Prevention System (PBPS)</u> A web-based MIS, PBPS, collects administrative and outcome data on all DBHR's Substance Abuse Block Grant funded substance abuse prevention services. <u>https://waprev.onmosaix.com/waprevent2015/pEnter.aspx</u>
- <u>RMC Research's Student Assistance Prevention and Intervention Services Program (SAPISP)</u> <u>Database</u> – This automated web-based reporting system is used to monitor service provision and student outcomes throughout the school year of participants in the local Student Assistance Prevention and Intervention Services Programs.
- <u>Treatment and Assessment Reports Generation Tool (TARGET)</u> This system records outpatient demographic and service encounter data for substance abuse, and client and service encounter information for both Medicaid and non-Medicaid-funded services.

- <u>ProviderOne</u> This system records and stores all Medicaid claims for outpatient and residential substance abuse treatment services and all encounter data for Medicaid-funded outpatient mental health managed care services and residential claims for mental health treatment.
- <u>Catalyst</u> –Web-based system utilized to collect and provide summary information pertaining to Department of Health's Tobacco Prevention and Control project and Community Transformation grant activities statewide.
- Office of the Superintendent of Public Instruction (OSPI) Report cards The School Report Card is a parent-friendly resource for data on student demographics, student performance, and school staff in our state. <u>http://reportcard.ospi.k12.wa.us/summary.aspx?year=2010-11</u>
- <u>Mental Health Consumer Information System (MHCIS)</u> Demographic information for all mental health consumers and non-Medicaid mental health service data are entered into MHCIS.
- Integrated Client Database (ICDB) DSHS' longitudinal client database containing ten or more years of detailed service risks, history, costs, and outcomes.
- <u>Comprehensive Hospital Abstract Reporting System (CHARS)</u> Includes coded hospital inpatient discharge information (derived from billing systems) available for 1987 to 2010. <u>http://www.doh.wa.gov/ehsphl/hospdata/chars.htm</u>

## 5. Data Assessment

The following is a compilation of the Data Assessment presentations provided at the March and April, 2015 Consortium meetings *is available online at: <u>www.TheAthenaForum.org/SPE</u>.* 

The table below summarizes the findings from the review of substances:

#### 2011 Baseline Ranking

| Ranking                              | Alcohol  | Tobacco   | Marijuana  | Meth                                 | Prescription<br>Drug                              |  |
|--------------------------------------|--|---|--|--------------------------------------|---|--|
| Prevalence<br>Rates<br>(youth/adult) | 1 <sup>st</sup> -youth<br>1 <sup>st</sup> -adults  | 3 <sup>rd</sup> -youth<br>2 <sup>nd</sup> -adults | 2 <sup>nd</sup> -youth<br>3 <sup>rd</sup> -adults    | 5 <sup>th</sup> -youth<br>NA- adults | 4 <sup>th</sup> -youth<br>4 <sup>th</sup> -adults |  |
| Trends<br>(youth/adult)              | no trend<br>change   | no trend<br>change                                | youth -<br>increasing<br>adult-<br>increase in<br>WA | no trend<br>change                   | no trend change                                   |  |
| Economic<br>Impacts                  | 1 <sup>st</sup>  | 3 <sup>rd</sup>                                   | Illicit drugs: 2 <sup>nd</sup>                       |                                      |   |  |
| Social Impact                        | <ul> <li>Deaths: alcohol greater impact than illicit drugs</li> <li>Drinking and driving: Age dependent</li> <li>Traffic injuries and fatalities: Age dependent</li> <li>School related consequences: Mixed</li> </ul> |   |  |                                      |   |  |
| OVERALL                              | 1st  | 3rd   | 2nd  | 5th                                  | 4th   |  |

Notes: \*Substances are ranked from the highest prevalence to the lowest. The first number indicates the ranking for youth and the second number indicates the ranking for adults (+18). \*\*Substances are ranked based on trends. The first number indicates the ranking for youth and the second number indicates the ranking for adults (18+). With the exception of youth marijuana use, there has not been any discernible increasing or decreasing trends in these five substances. Youth marijuana use, therefore, was given the highest ranking.

| Ranking                              | Alcohol  | Tobacco   | Marijuana  | Meth                                 | Prescription<br>Drug                              |
|--------------------------------------|--|---|--|--------------------------------------|---|
| Prevalence<br>Rates<br>(youth/adult) | 1 <sup>st</sup> -youth<br>1 <sup>st</sup> -adults  | 3 <sup>rd</sup> -youth<br>2 <sup>nd</sup> -adults | 2 <sup>nd</sup> -youth<br>3 <sup>rd</sup> -adults  | 5 <sup>th</sup> -youth<br>NA- adults | 4 <sup>th</sup> -youth<br>4 <sup>th</sup> -adults |
| Trends<br>(youth/adult)              | decrease   | decrease  | Slight increase<br>for 12 <sup>th</sup> Grade<br>adult - no<br>significant<br>change in<br>2014 data | no trend<br>change                   | decrease  |
| Economic<br>Impacts                  | 1 <sup>st</sup>  | 3 <sup>rd</sup>                                   | Illicit drugs: 2 <sup>nd</sup>   |                                      |   |
| Social Impact                        | <ul> <li>Deaths: alcohol greater impact than illicit drugs</li> <li>Drinking and driving: Age dependent</li> <li>Traffic injuries and fatalities: Age dependent</li> <li>School related consequences: Mixed</li> </ul> |   |  |                                      |   |
| OVERALL                              | 1st  | 3rd   | 2nd  | 5th                                  | 4th   |

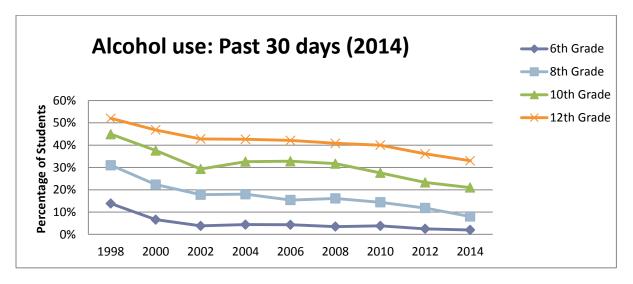
# 2015 Update Ranking

## Following charts are the main data that were considered as part of our assessment: Health Youth Survey (HYS): *Figures HYS 1-18*

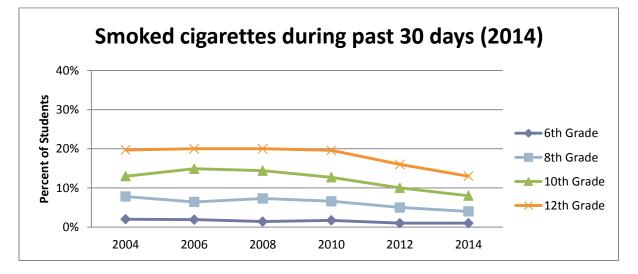
Notes:

- Statewide school survey conducted biannually.
- Collects data on health risk behaviors that contribute to morbidity, mortality, and social problems among youth.

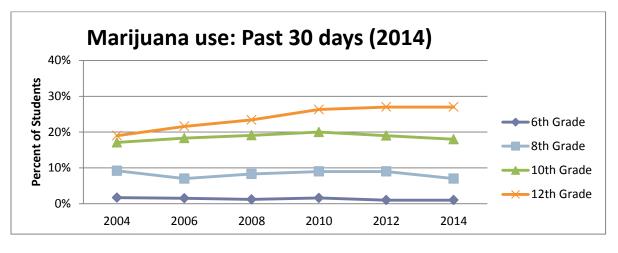
- Respondents: students in the 6th, 8th, 10th, and 12th grades.
- Sample size (2010): 211,331 students from 1,145 schools.
- Sample size (2014): 223,202 students.
- In 2014, a pilot project included 7<sup>th</sup>, 9<sup>th</sup>, and 11<sup>th</sup> graders.

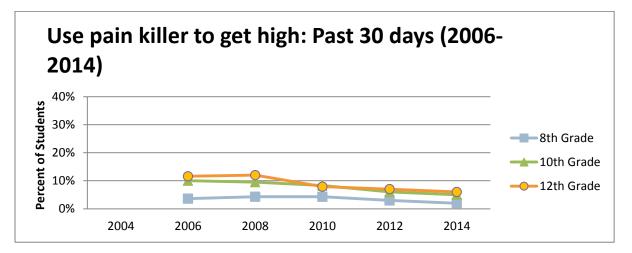


HYS - Figure 2

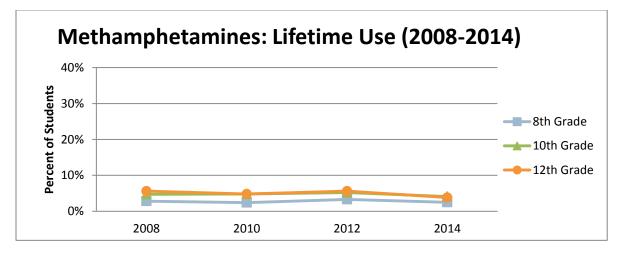


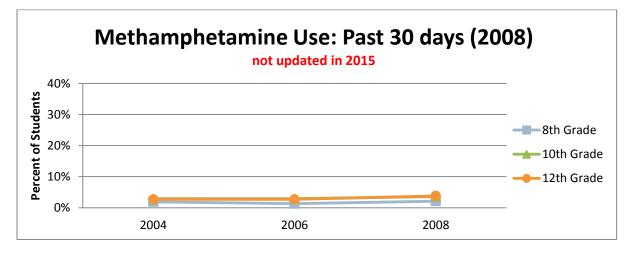


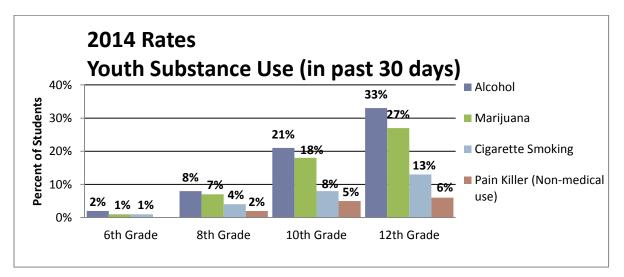




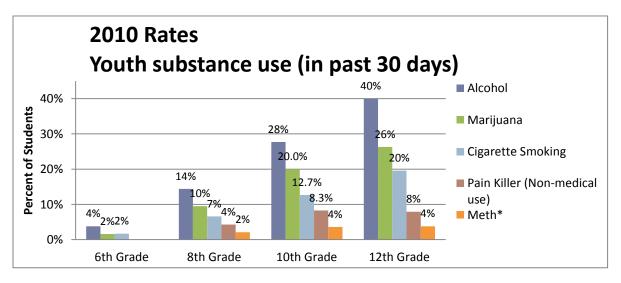


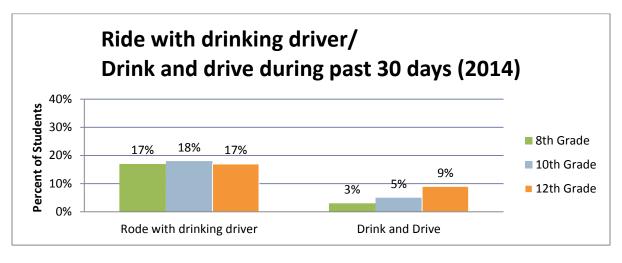




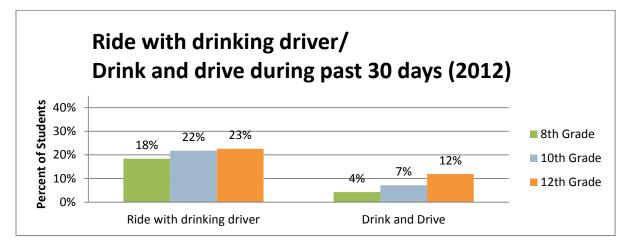


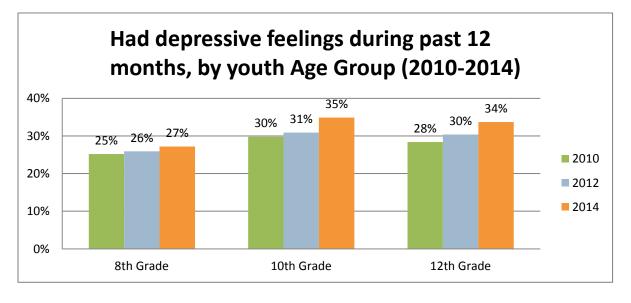


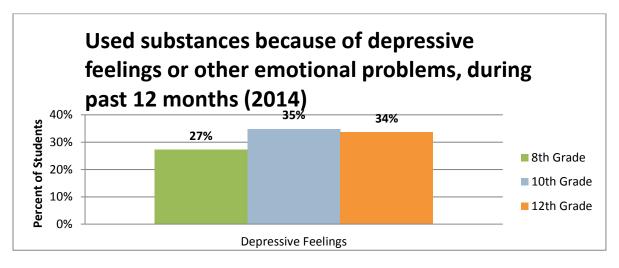


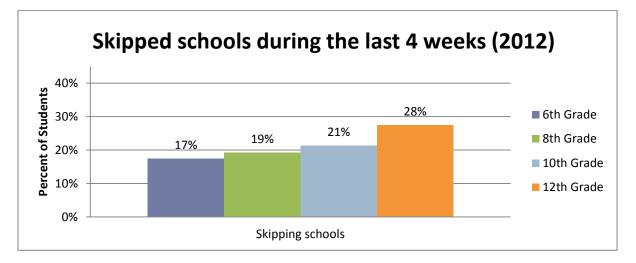


#### HYS - Figure 10

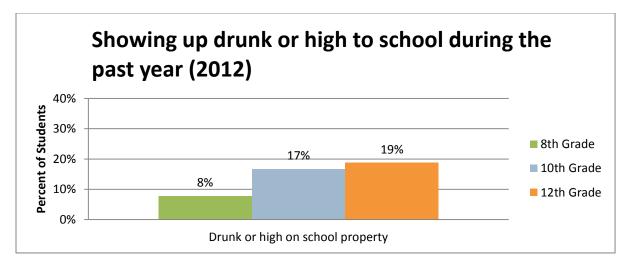


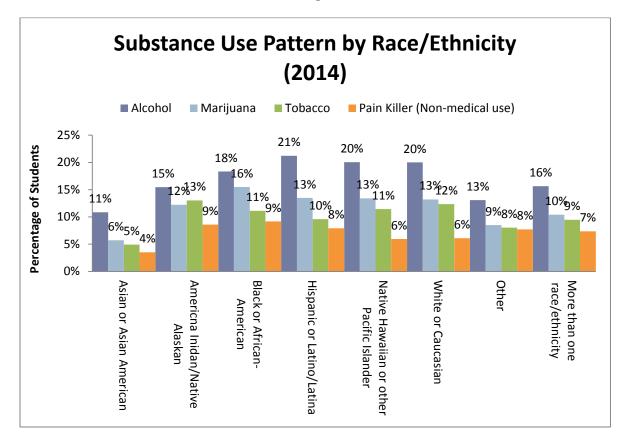


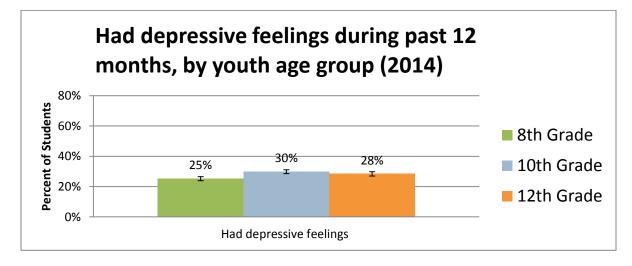


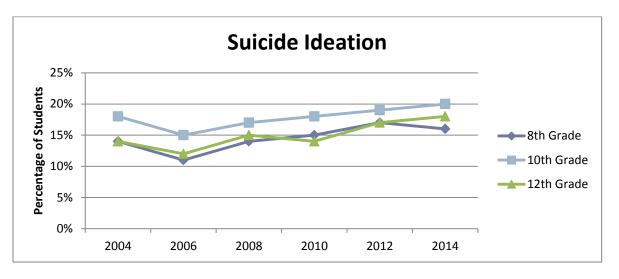












| HYS - | Figure | 18 |
|-------|--------|----|
|       | 1 BMIC |    |

# Correlation between substance use and negative consequences (Odds Ratio)

|                                    | Alcohol | Marijuana | Pain Killer* | Tobacco |
|------------------------------------|---------|-----------|--------------|---------|
| Depressive Feelings                | 2.3     | 2.0       | 3.1          | 2.3     |
| Drunk or high at school            | 12.6    | 24.7      | 22.3         | 14.0    |
| Riding with driver who had alcohol | 6.0     | 4.8       | 7.3          | 4.9     |
| Skipping school                    | 3.5     | 4.1       | 5.0          | 4.1     |

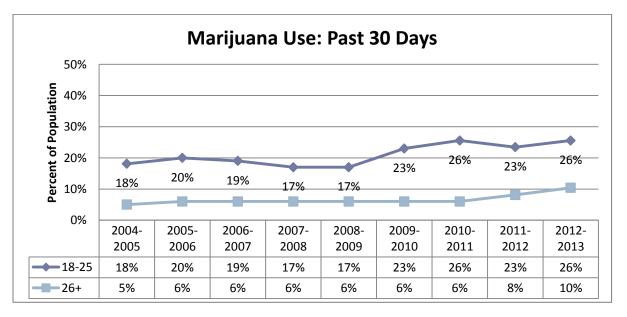
Source: 2010 HYS. This data not updated in 2015.

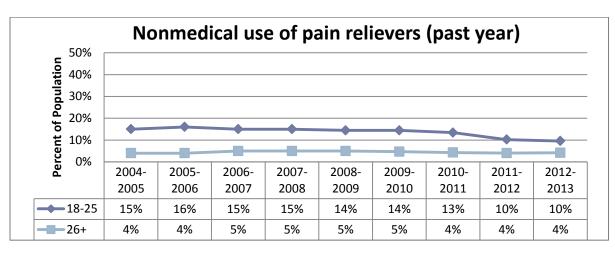
\* Used pain killers to get high

# National Survey on Drug Use and Health (NSDUH): Figures NSDUH 1-13

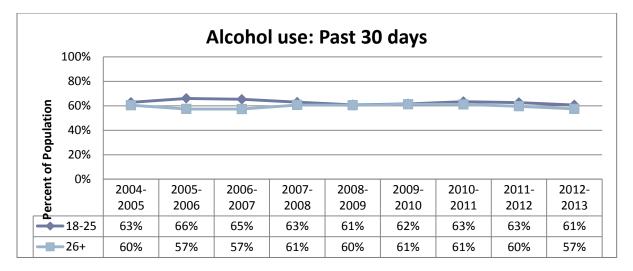
Notes:

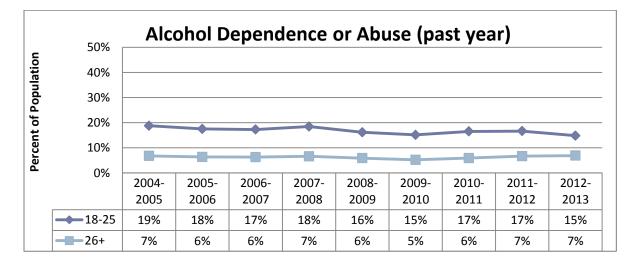
- Nationwide annual survey conducted through computerized interviews.
- Collects data on the use of tobacco, alcohol, illicit drugs (including non-medical use of prescription drugs) and mental health indicators.
- Respondents: individuals 12 years and older.
- Sample size: approximately 70,000 nationally.
- Estimating Rates of Mental Illness
  - Psychological distress measured by Kesseler-6 distress scale.
  - Functional impairment measured by the World Health Organization Disability Assessment Schedule (WHODAS) and the Sheehan Disability Scale (SDS).
  - Conducted clinical interviews with a subsample to determine mental illnesses.
  - Rates of mental illness estimated using statistical models based on K-6, WHODAS/SDS, and parameters determined by the clinical interviews.
- Estimating Rates of Depression
  - Major depressive episode: defined as in DSM-IV a period of at least 2 weeks when a person experienced a depressed mood or loss of interest or pleasure in daily activities and had a majority of specified depression symptoms.
  - Adult questions adapted from the National Comorbidity Survey Replication (NCS-R).
  - Youth (12 to 17) questions adapted from the National Comorbidity Survey Adolescent (NCS-A).

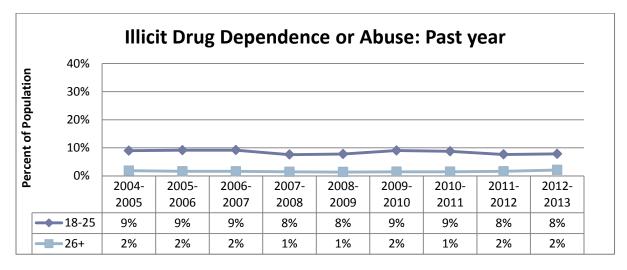




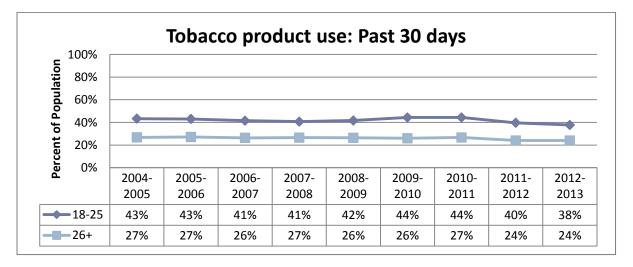
#### NSDUH - Figure 3

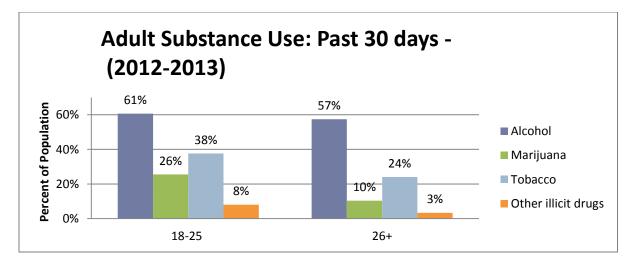


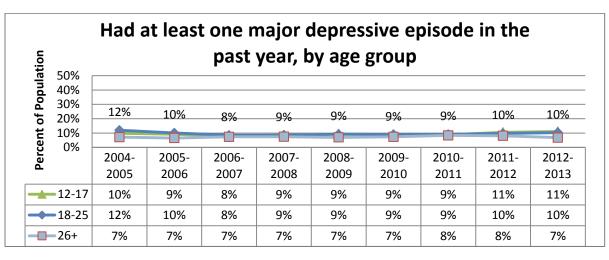


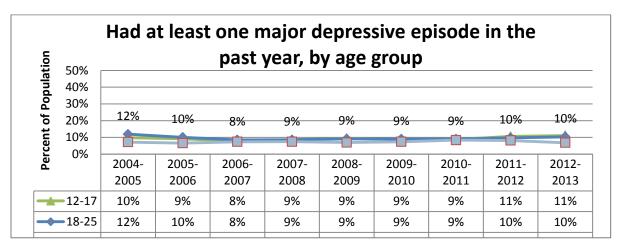


#### NSDUH - Figure 6

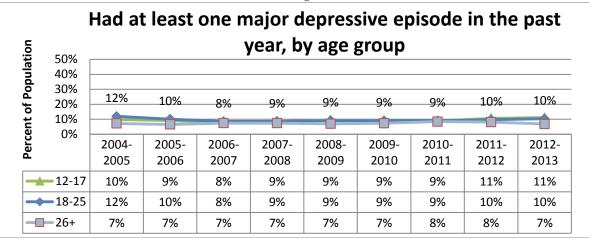


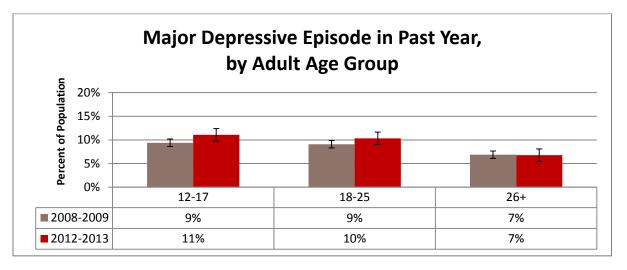




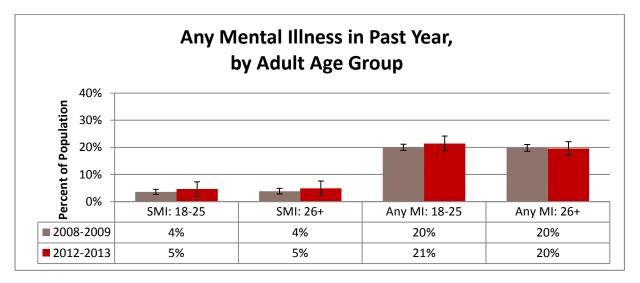


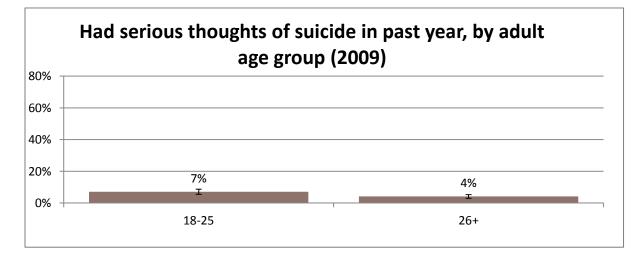






#### NSDUH - Figure 12

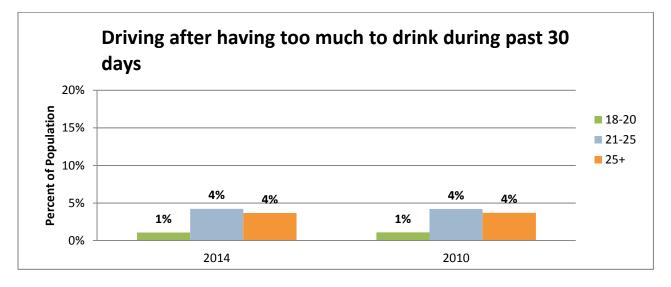




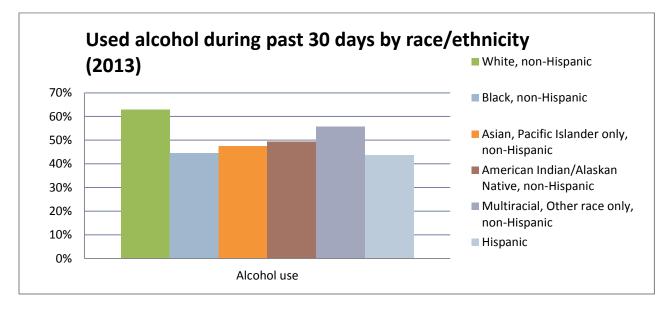
# Behavioral Risk Factors Surveillance System (BRFSS): Figures BRFSS 1-28

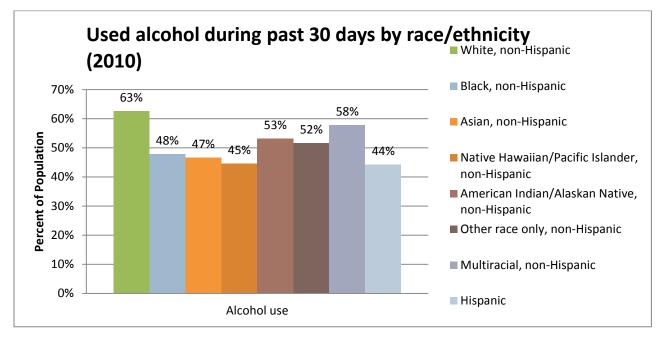
Notes:

- National and statewide annual telephone survey.
- Collects information on health behaviors and preventive practices.
- Respondents: adults 18 years and older.
- Sample size (2010): approximately 20,000 in Washington State.
- Annual Survey in 2013 was provided for the Strategic Plan Update 2015.
- Sample size (2013): approximately 10,000 in Washington State.
- Measuring Serious Psychological Distress (BRFSS)
  - Measured by Kessler-6 distress scale.
  - Serious psychological distress defined as a score of 13 or more on K-6.

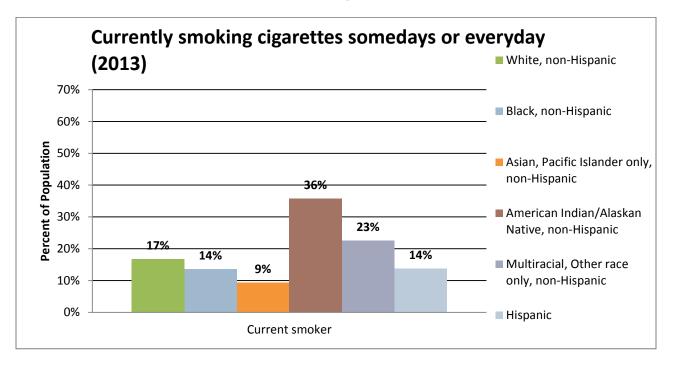


BRFSS - Figure 2

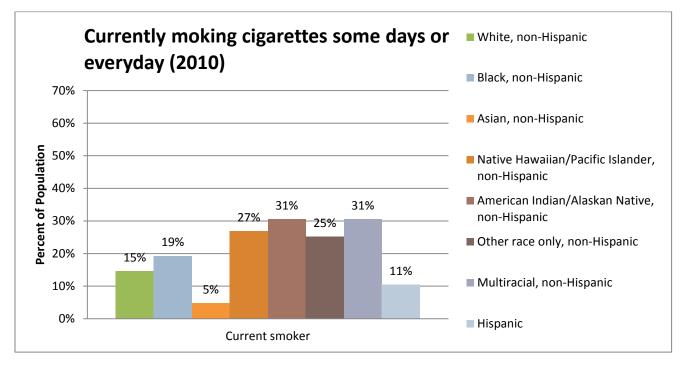




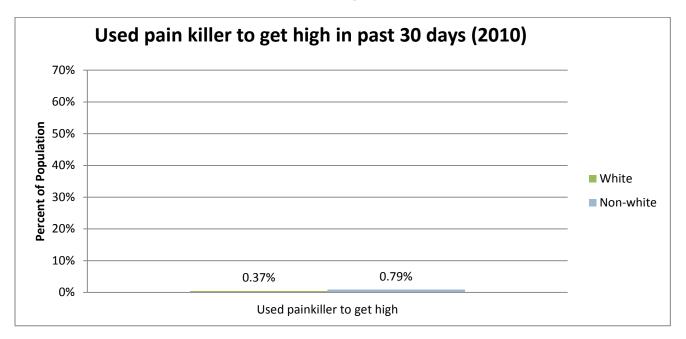
**BRFSS - Figure 4** 

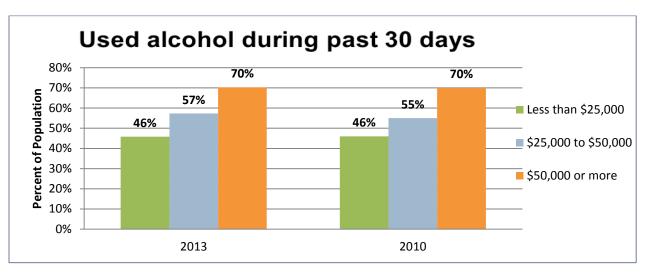


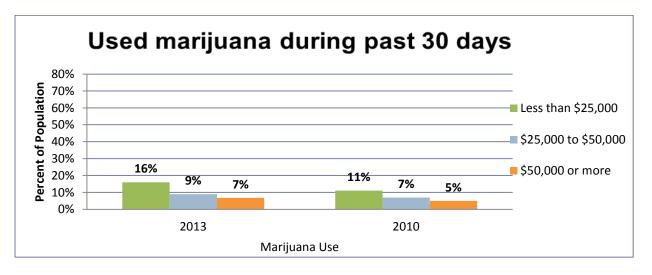




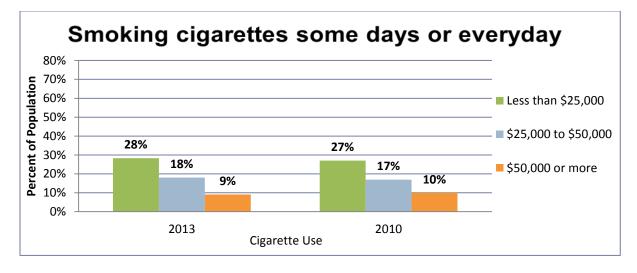




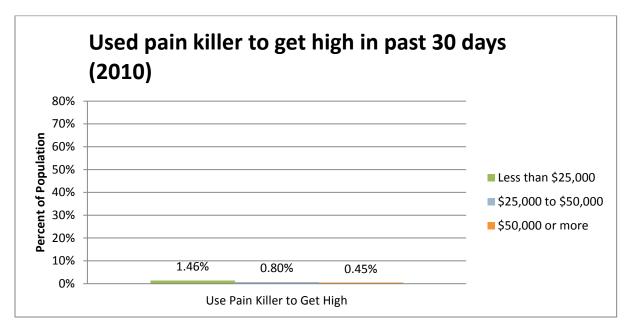


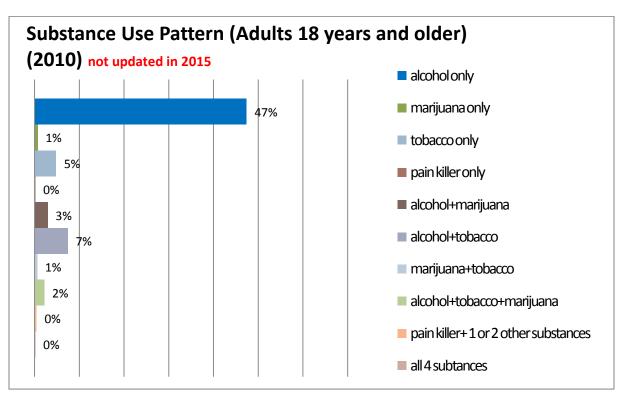


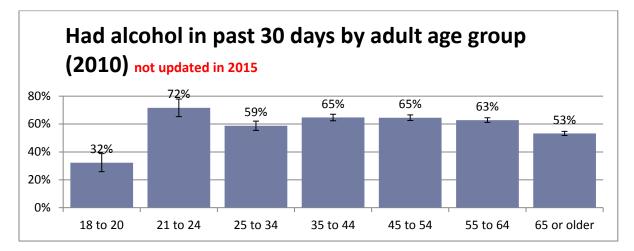




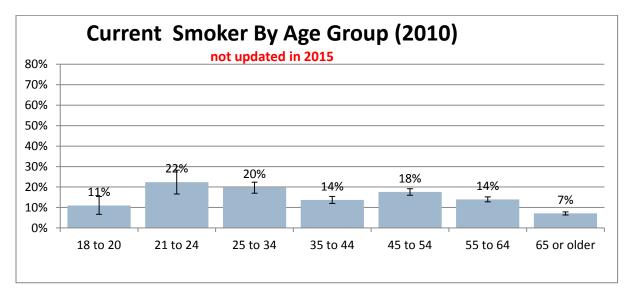


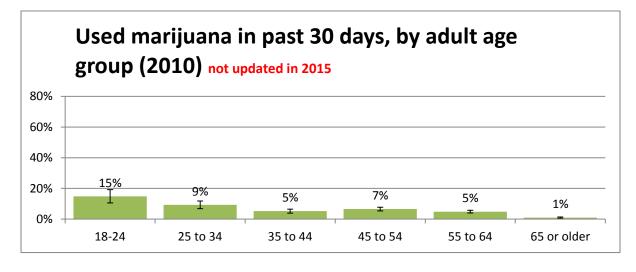


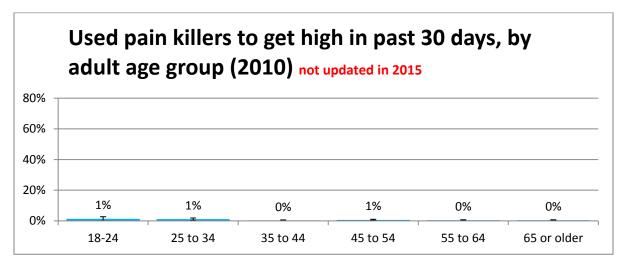


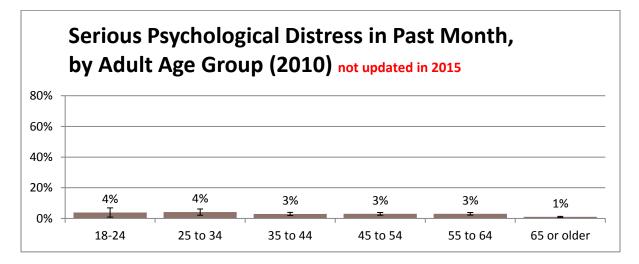


#### BRFSS - Figure 13

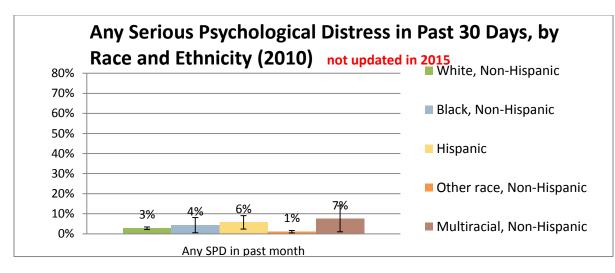


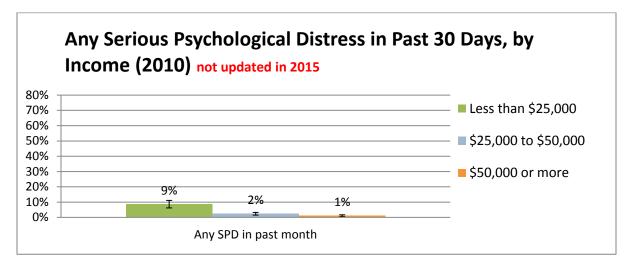




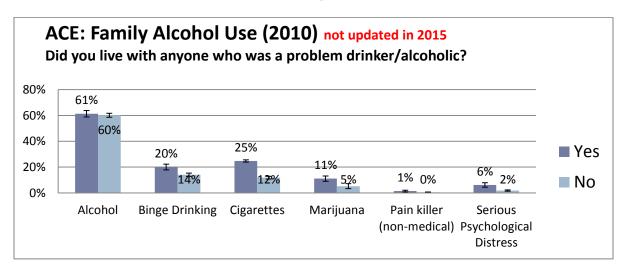


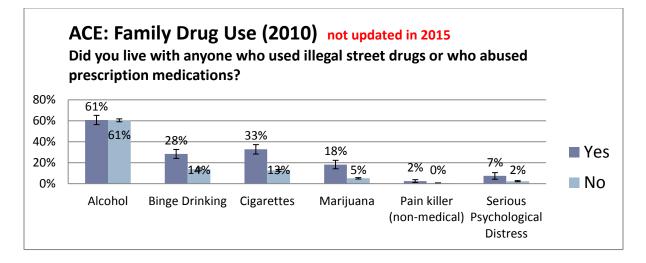


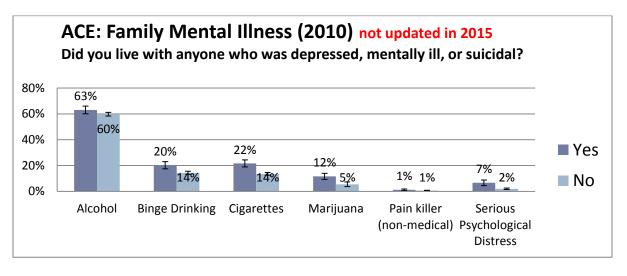




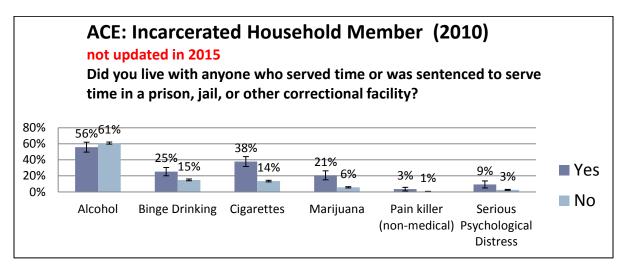
#### **BRFSS - Figure 19**

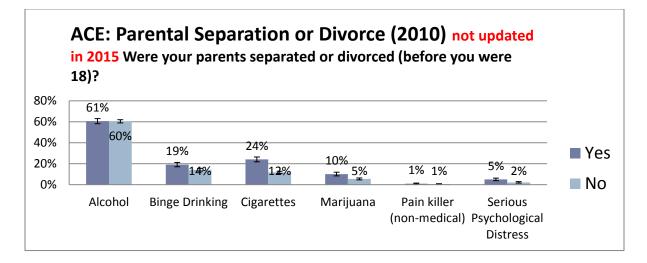


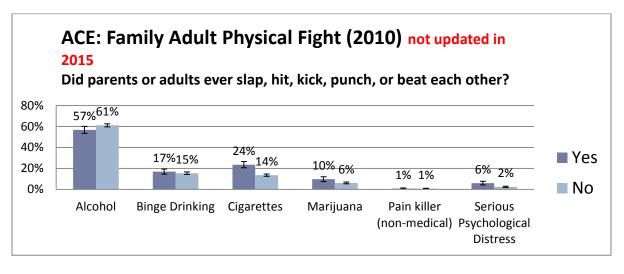




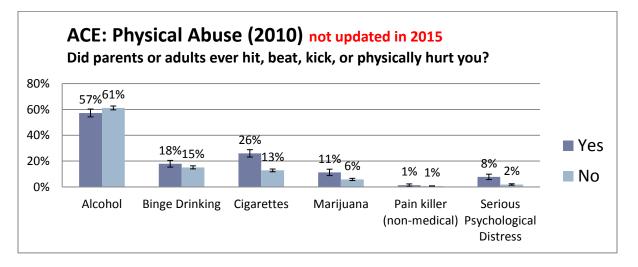
BRFSS - Figure 22

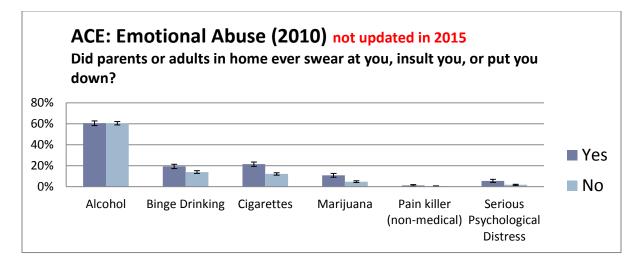


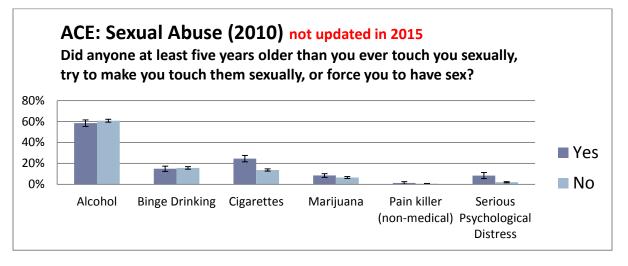




**BRFSS - Figure 25** 







#### BRFSS - Figure 28

| ACEs:                             | Drinking<br>Alcohol | Binge<br>Drinking | Smoking<br>Cigarettes | Using<br>Marijuana | Using<br>Pain<br>Killers to<br>Get High | Serious<br>Psychological<br>Distress |
|-----------------------------------|---------------------|-------------------|-----------------------|--------------------|---|--------------------------------------|
| Family Drinking                   | 1.05                | 1.54              | 2.46                  | 2.28               | 2.92                                    | 3.53                                 |
| Family Drug Use                   | 1.01                | 2.47              | 3.36                  | 4.15               | 5.18                                    | 3.40                                 |
| Family Mental Illness             | 1.15                | 1.51              | 1.77                  | 2.28               | 1.96                                    | 3.45                                 |
| Household Members<br>Incarcerated | 0.81                | 1.93              | 3.90                  | 4.31               | 6.92                                    | 4.01                                 |
| Parents Divorced or<br>Separated  | 1.01                | 1.43              | 2.39                  | 1.95               | 1.49                                    | 2.41                                 |
| Family Adult Physical Fight       | 0.84                | 1.12              | 1.96                  | 1.66               | 1.08                                    | 2.60                                 |
| Physical Abuse                    | 0.85                | 1.22              | 2.39                  | 2.06               | 2.40                                    | 4.44                                 |
| Emotional Abuse                   | 1.00                | 1.48              | 1.97                  | 2.43               | 2.66                                    | 3.34                                 |
| Sexual Abuse                      | 0.91                | 0.94              | 2.05                  | 1.33               | 2.26                                    | 4.30                                 |

\* This diagram was not updated in the 2015 Strategic Plan Update. ACEs questions not asked on latest version of BRFSS.

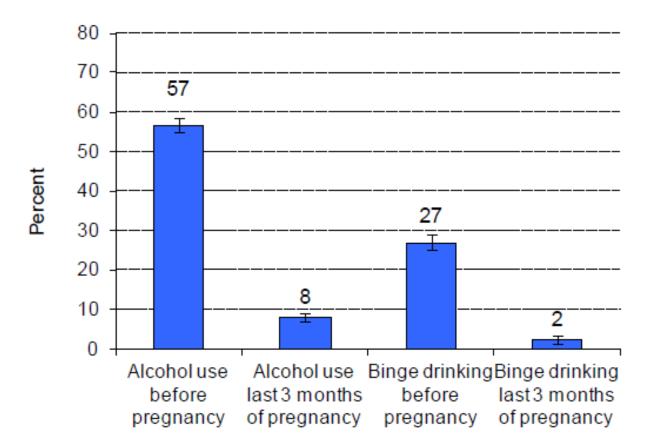
# Pregnancy Risk Assessment Monitoring System (PRAMS): Figures PRAMS 1-9

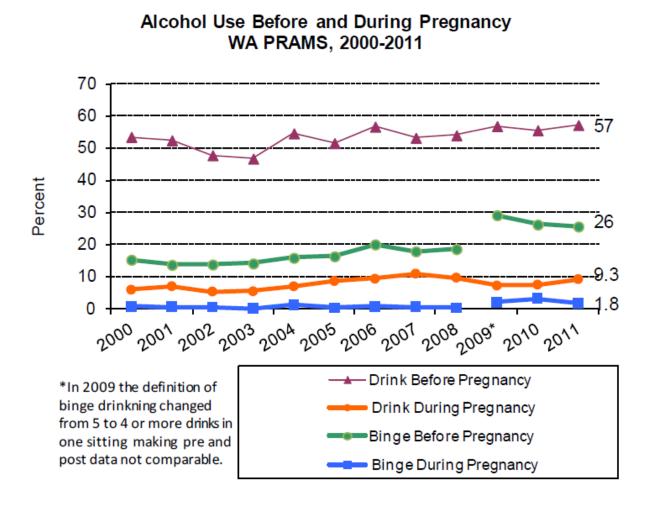
Notes:

- National and statewide mail and telephone survey.
- Collects data on new mothers' behaviors and experiences before, during, and shortly after pregnancy.
- Respondents: new mothers 2 to 6 months after delivering a baby.
- Sample size: approximately 1,800 surveys mailed each year in Washington with about a 76% response rate.
- PRAMS information was included in the 2015 update to include 2009-2011 data.

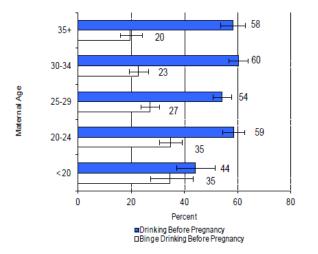
#### PRAMS - Figure 1

# Alcohol Use Before and During Pregnancy WA PRAMS, 2009-2011

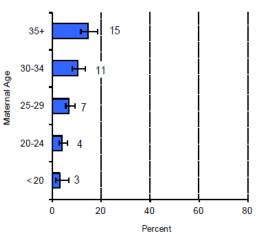




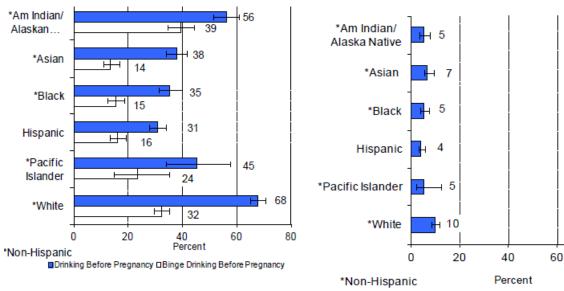
**PRAMS - Figure 3** 







Drinking In Third Trimester by Maternal Age, 2009-2011

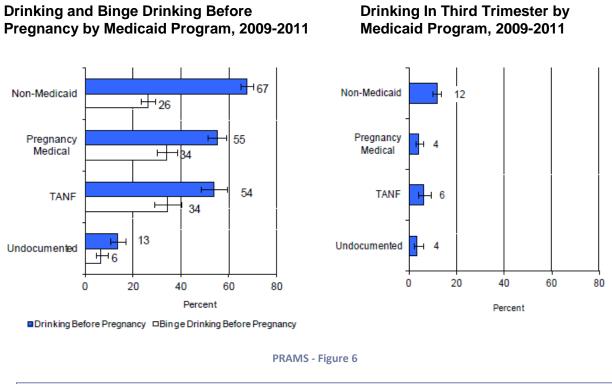


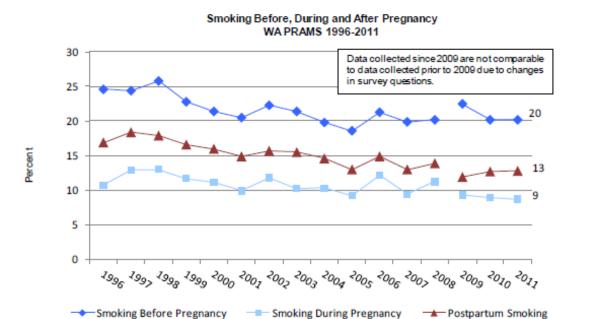
# Drinking and Binge Drinking Before Pregnancy by Maternal Race/Ethnicity, 2009-2011

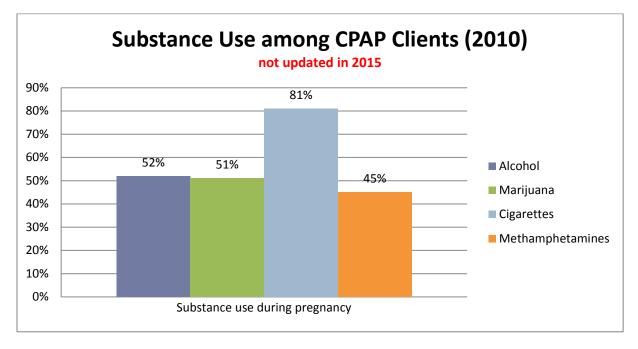


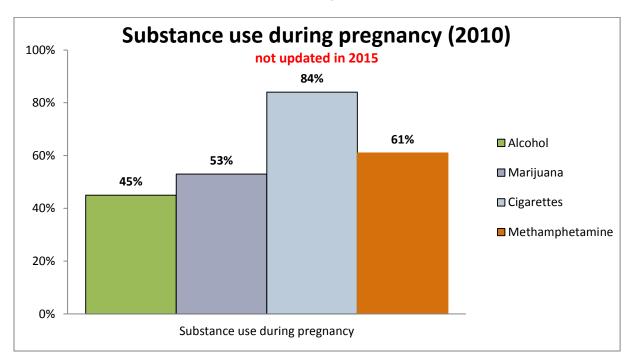
Notes: S-women, in the table below, are citizens who are eligible to receive Medicaid because they are pregnant and have income at or below 185% federal poverty line.

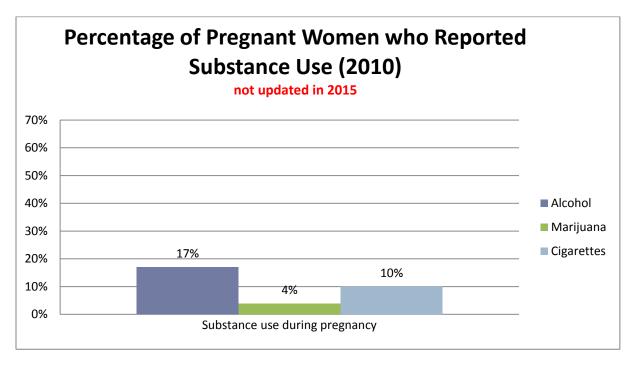
80









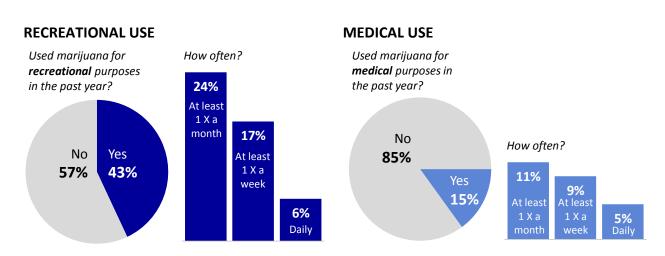


# Young Adult Survey 2014: Figures 1-2

Center for the Study of Health and Risk Behaviors at the University of Washington and the Department of Social and Health Services and the Washington State Epidemiological Outcomes Workgroup

### Notes:

- First Statewide Young Adult Survey in Washington State.
- Internet based survey conducted from May through early July of 2014.
- Survey Participation 2,101 Washington residents aged 18-25.
  - County level participation: 39 counties participated



#### YAHS - Figure 1



# During the past 30 days, how many times did you drive a car or other vehicle within three hours after using cannabis?

Among the young adults who have used marijuana in the past month, almost half report they have driven a car within three hours of using marijuana

| No <b>51%</b> | Yes <b>49</b> 9      | 6 —                     | 4                |                                  |
|---------------|----------------------|-------------------------|------------------|----------------------------------|
| 0 times       | 1 time<br><b>14%</b> | 2-3 times<br><b>13%</b> | 4-5<br><b>6%</b> | 6 or more<br>times<br><b>16%</b> |

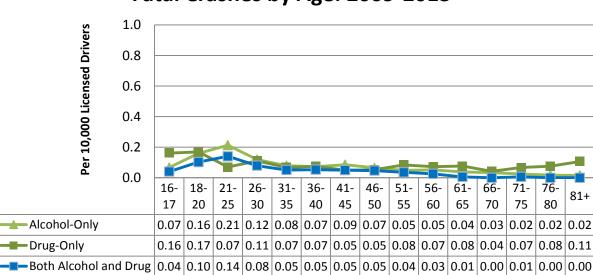
# **Traffic Data:** Figures Traffic Data 1-3 Fatality Analysis Reporting System (FARS)

Notes:

- Nationwide census with data regarding fatal injuries suffered in motor vehicle traffic crashes.
- Maintained by National Highway Traffic Safety Administration (NHTSA).
- Data available yearly from 1975.
- Collects data on crashes involving a motor vehicle traveling on a traffic way customarily open to the public and resulting in the death of a person within 30 days of the crash.
- Counts of DUI arrests and Fatal Crashes declining (2009-2013 data) similar to historical and national trends

**Traffic Data - Figure 1** 

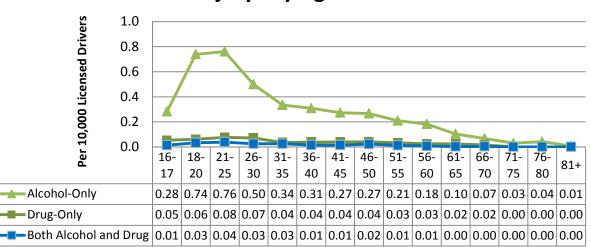
- Increased use of "ignition interlock devices"
- Conclusion: DUI/crash impacts inconclusive (for now)



# Fatal Crashes by Age: 2009-2013

Sources: Data provided by the Washington Traffic Safety Commission. Fatality Analysis Reporting System (FARS), March 2015. Department of Licensing (data on licensed drivers by age/year), March 2015.

Traffic Data - Figure 2



# Serious Injurys by Age: 2009-2013

Sources: Data provided by the Washington Traffic Safety Commission. Fatality Analysis Reporting System (FARS), March 2015. Department of Licensing (data on licensed drivers by age/year).

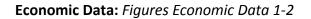
#### Traffic Data - Figure 3

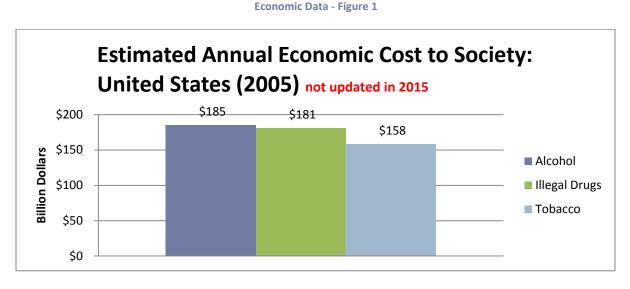
| Turch Turch Views                     | 2003-2005 |                      | 2006-2008 |                      | 2009-2011 |                      | 2012-2014* |                      | 2012-2014*<br>v. 2009-2011            |  |
|---------------------------------------|-----------|----------------------|-----------|----------------------|-----------|----------------------|------------|----------------------|---------------------------------------|--|
| Target Zero Years                     | Deaths    | % of Total<br>Deaths | Deaths    | % of Total<br>Deaths | Deaths    | % of Total<br>Deaths | Deaths     | % of Total<br>Deaths | Percent Change in<br>Number of Deaths |  |
| Total Fatalities                      | 1,816     | 100.0%               | 1,725     | 100.0%               | 1,406     | 100.0%               | 1,333      | 100.0%               | -5.2%                                 |  |
| Priority One                          |           |                      |           |                      |           |                      |            |                      |                                       |  |
| Alcohol/Drug Impaired Driver-Involved | 794       | 43.7%                | 827       | 47.9%                | 704       | 50.1%                | 647        | 48.5%                | -8.1%                                 |  |
| Drinking Driver-Involved              | 706       | 38.9%                | 712       | 41.3%                | 610       | 43.4%                | 478        | 35.9%                | -21.6%                                |  |
| Alcohol Impaired Driver-Involved      | 557       | 30.7%                | 544       | 31.5%                | 476       | 33.9%                | 364        | 27.3%                | -23.5%                                |  |
| Drug Impaired Driver-Involved         | 412       | 22.7%                | 473       | 27.4%                | 416       | 29.6%                | 448        | 33.6%                | 7.7%                                  |  |
| Run Off the Road                      | 765       | 42.1%                | 720       | 41.7%                | 615       | 43.7%                | 516        | 38.7%                | -16.1%                                |  |
| Speeding Driver-Involved              | 707       | 38.9%                | 693       | 40.2%                | 555       | 39.5%                | 504        | 37.8%                | -9.2%                                 |  |

# Traffic Fatalities - WSDOT, Target Zero Priority One

Source: Data provided by the Washington Traffic Safety Commission, Washington Department of Transportation, Target Zero, April 2015.

Note: \* 2014 figures are based on preliminary data, and are subject to change up until 11:59 PM on December 31, 2015.

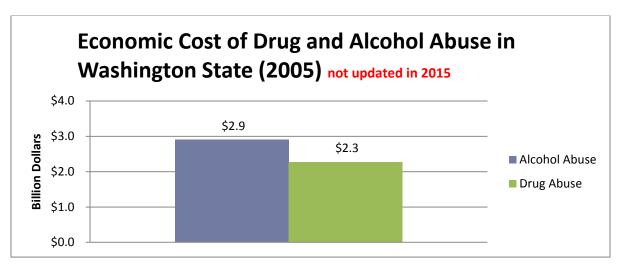




Source: Surgeon General's Report, 2004; ONDCP, 2004; Harwood, 2000, quoted in NIDA (2008). Addition Science: From Molecules to Managed Care. http://www.drugabuse.gov/publications/addiction-science

Note: Economic costs include specialty treatment, medical consequences, lost earnings, and other costs such as accidents and criminal justice.

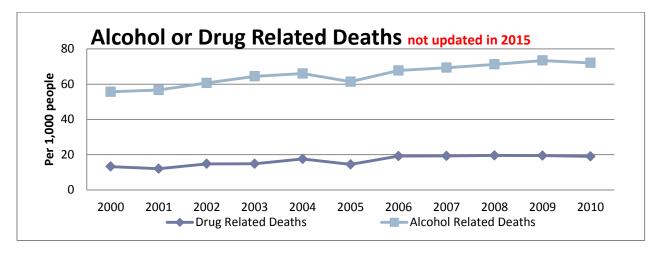
#### Economic Data - Figure 2



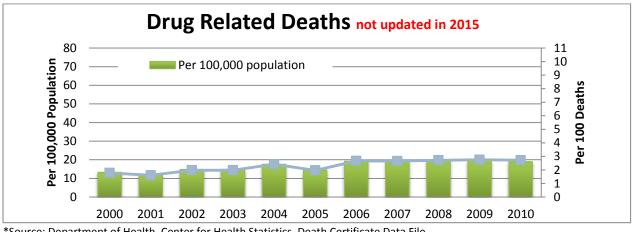
Source: Computed from Wickizer, T. The Economic Costs of Drug and Alcohol Abuse in Washington State, 2005. Olympia, WA: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, 2007.

Death Data: Figures Death Data 1-3

Death Data - Figure 1

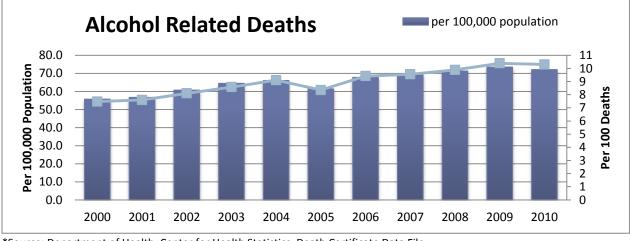


#### Death Data - Figure 2



\*Source: Department of Health, Center for Health Statistics, Death Certificate Data File

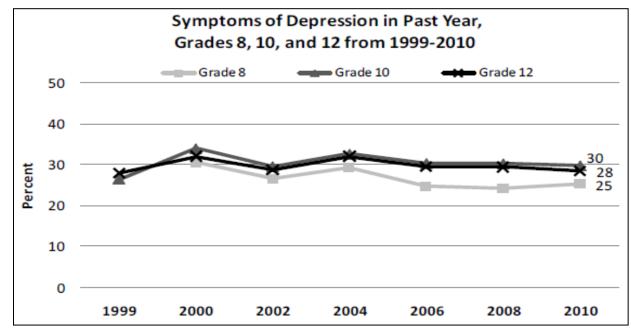
#### Death Data - Figure 3



\*Source: Department of Health, Center for Health Statistics, Death Certificate Data File

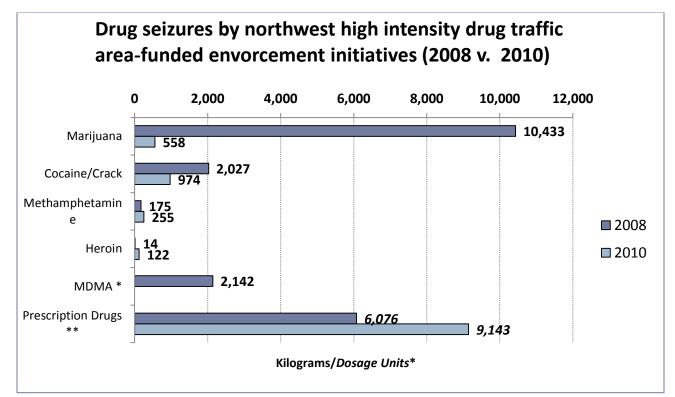
Other Data: Figures Other data 1-2

Other Data - Figure 1



Source: YRBS, 1999, WASSAHB, 2000, HYS, 2002, 2004, 2006, 2008, 2010

#### Other Data - Figure 2

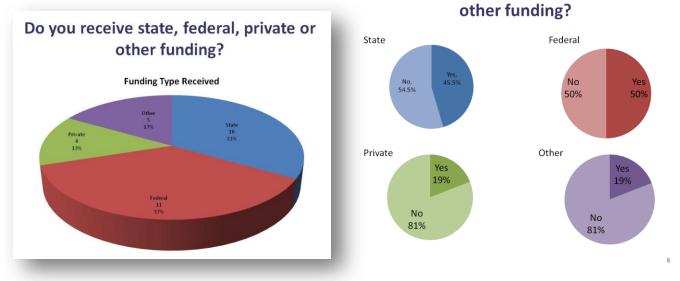


Source: U.S. Department of Justice, National Drug Intelligence Center. Northwest High Intensity Drug Trafficking Area Drug Market Analysis, 2011-R0813-023, September 2011.

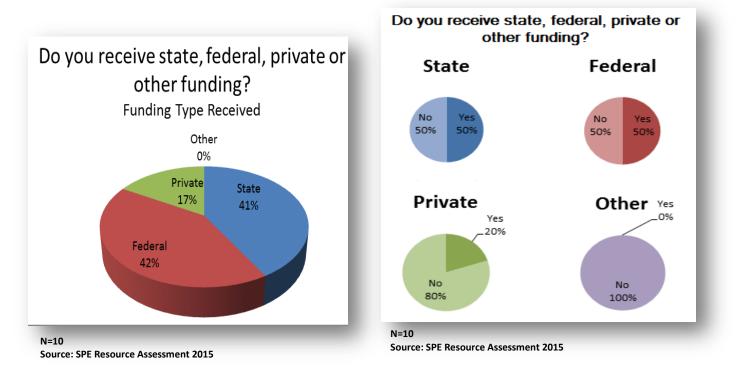
# 6. Resource Assessment

The information that follows is a summary of the survey results of the Resources Assessment. Consortium partners responded to a series of questions regarding funding and resources they provide. A compilation of the Resources Assessment presentation provided *is available online at:* <u>www.TheAthenaForum.org/SPE</u>.

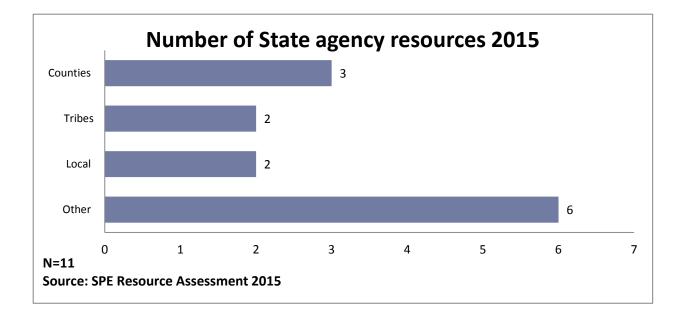
# **Funding Information**



Do you receive state, federal, private or other funding?



#### Resources - Figure 1



# 7. Resources Assessment

Below is a quick reference of which counties have funds allocated to them from the listed agency. The arrow indicates comparison to median for number of resources per county.

|              | State | e Agen | cy Res | ources a | llocated | l to Coun | ties    |                             |      |
|--------------|-------|--------|--------|----------|----------|-----------|---------|-----------------------------|------|
| County       | СМОВ  | DBHR   | DEL    | DOH      | WSP      | WTSC      | NWHIDTA | Subto                       | otal |
| Adams        | х     | x      | х      | х        |          |           |         | Ļ                           | 4    |
| Asotin       | х     | х      |        | x        |          |           |         | Ļ                           | 3    |
| Benton       | x     | x      |        | x        |          | х         | x       | -                           | 5    |
| Chelan       | х     | x      |        | x        |          | х         |         | Ļ                           | Z    |
| Clallam      | х     | х      |        | х        |          | х         |         | Ļ                           | Z    |
| Clark        | x     | х      |        | x        |          | x         | x       | ->                          | 5    |
| Cowlitz      | x     | x      | x      | x        |          | х         | x       |                             | 6    |
| Columbia     | x     | x      |        | x        |          |           |         | Ļ                           | 3    |
| Douglas      | x     | х      |        | х        |          | x         |         | Ļ                           | 4    |
| Ferry        | x     | x      |        | x        |          | x         |         | Ļ                           | 4    |
| Franklin     | x     | x      | х      | x        |          | x         | x       |                             | 6    |
| Garfield     | x     | х      |        | x        |          |           |         | Ļ                           | 3    |
| Grant        | х     | х      |        | x        |          | х         |         | Ļ                           | 4    |
| Grays Harbor | x     | x      | x      | x        |          | х         |         | ->                          | 5    |
| Island       | x     | х      |        | x        |          |           |         | Ļ                           | Э    |
| Jefferson    | х     | x      |        | x        |          | х         |         | Ļ                           | 4    |
| Klickitat    | x     | x      |        | x        |          |           |         | Ļ                           | 3    |
| Kitsap       | x     | х      |        | x        |          | x         | x       | $\Rightarrow$               | 5    |
| Kittitas     | x     | х      |        | x        |          | x         |         | Ļ                           | 4    |
| King         | х     | x      | х      | x        | x        | х         | x       |                             | 7    |
| Lewis        | x     | x      |        | x        |          | x         | x       | $\Rightarrow$               | 5    |
| Lincoln      | x     | х      |        | х        |          | x         |         | Ļ                           | Z    |
| Mason        | х     | x      | х      | x        |          | х         |         | ->                          | 5    |
| Okanogan     | x     | x      | x      | x        |          |           |         | Ļ                           | 4    |
| Pacific      | x     | х      | х      | x        |          | х         |         | -                           | 5    |
| Pend Oreille | х     | x      | х      | x        |          |           |         | Ļ                           | 4    |
| Pierce       | х     | x      |        | x        | х        | х         | x       |                             | 6    |
| San Juan     | х     | х      |        | x        |          |           |         | Ļ                           | 3    |
| Skagit       | х     | x      | х      | x        |          | х         | x       |                             | 6    |
| Skamania     | х     | x      |        | x        |          |           |         | Ļ                           | Э    |
| Snohomish    | х     | х      | х      | x        | х        | х         | x       |                             | 7    |
| Spokane      | x     | x      | х      | x        |          | х         | x       | 1                           | 6    |
| Stevens      | х     | x      |        | x        |          |           |         | Ţ                           | З    |
| Thurston     | x     | x      |        | x        |          | x         | x       | $\Rightarrow$               | 5    |
| Wahkiakum    | x     | x      |        | x        |          |           |         | Ļ                           | Э    |
| Walla Walla  | x     | x      |        | x        |          | x         |         | Ļ                           | Z    |
| Whatcom      | x     | x      |        | x        |          |           | х       | Ļ                           | Z    |
| Whitman      | x     | x      |        | x        |          |           |         | Ļ                           | 3    |
| Yakima       | x     | x      | x      | x        |          | x         | x       | $\mathbf{\dot{\mathbf{A}}}$ | e    |

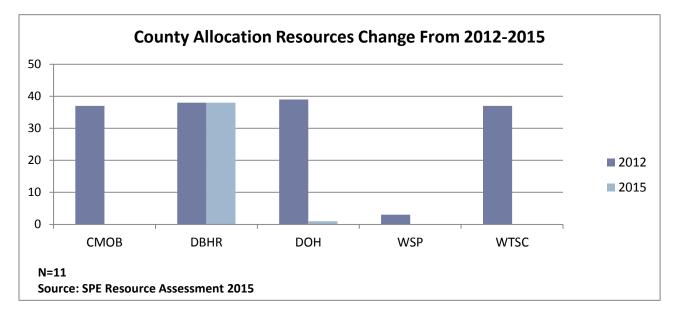
| County       | Cmob | DBHR | DEL | DOH | WSP | WTSC | NWHIDTA | Subto         | otal |
|--------------|------|------|-----|-----|-----|------|---------|---------------|------|
| Adams        |      | х    | х   |     |     |      |         |               | 2    |
| Asotin       |      | х    |     |     |     |      |         | Ļ             | 1    |
| Benton       |      | x    |     |     |     | х    | х       | $\Rightarrow$ | 2    |
| Chelan       |      | x    |     |     |     | x    |         | $\Rightarrow$ | 2    |
| Clallam      |      | x    |     |     |     | х    |         | $\Rightarrow$ | 2    |
| Clark        |      | x    |     |     |     | x    | x       | $\Rightarrow$ | 2    |
| Cowlitz      |      | x    | х   |     |     | x    | x       | $\Rightarrow$ | Э    |
| Columbia     |      | x    |     |     |     |      |         | Ŷ             | 1    |
| Douglas      |      | x    |     |     |     | x    |         | $\Rightarrow$ | 2    |
| Ferry        |      | x    |     |     |     | х    |         | $\Rightarrow$ | 2    |
| Franklin     |      | x    | х   |     |     | х    | x       | $\Rightarrow$ | 3    |
| Garfield     |      | x    |     |     |     |      |         | Ŷ             | 1    |
| Grant        |      | x    |     |     |     | x    |         | ÷             | 2    |
| Grays Harbor |      | x    | х   |     |     | х    |         | $\Rightarrow$ | 3    |
| Island       |      | x    |     |     |     |      |         | ₽             | 1    |
| Jefferson    |      | x    |     |     |     |      |         | Ţ             | 1    |
| Klickitat    |      | x    |     |     |     |      |         | Ŷ             | 1    |
| Kitsap       |      | x    |     |     |     | х    | x       | $\Rightarrow$ | 2    |
| Kittitas     |      | x    |     |     |     | х    |         | $\Rightarrow$ | 2    |
| King         |      | x    | x   |     | x   | x    | x       |               | Z    |
| Lewis        |      | x    |     |     |     | x    | x       | $\Rightarrow$ | 2    |
| Lincoln      |      | x    |     |     |     | x    |         | $\Rightarrow$ | 2    |
| Mason        |      | x    | х   |     |     | x    |         | $\Rightarrow$ | Э    |
| Okanogan     |      | x    | х   |     |     |      |         | $\Rightarrow$ | 2    |
| Pacific      |      | x    | х   |     |     | x    |         | $\Rightarrow$ | Э    |
| Pend Oreille |      | x    | х   |     |     |      |         | $\Rightarrow$ | 2    |
| Pierce       |      | x    |     |     | x   | х    | x       | $\Rightarrow$ | 3    |
| San Juan     |      | x    |     |     |     |      |         | Ŷ             | 1    |
| Skagit       |      | x    | х   |     |     | x    | x       | $\Rightarrow$ | Э    |
| Skamania     |      | x    |     |     |     |      |         | Ŷ             | 1    |
| Snohomish    |      | x    | x   |     | х   | x    | x       |               | Z    |
| Spokane      |      | x    | x   |     |     | x    | x       | ⇒             | Э    |
| Stevens      |      | x    |     |     |     |      |         | Ļ             | 1    |
| Thurston     |      | x    |     |     |     | х    | x       | ÷             | 2    |
| Wahkiakum    |      | x    |     |     |     |      |         | Ļ             | 1    |
| Walla Walla  |      | x    |     |     |     | x    |         | ÷             | 2    |
| Whatcom      |      | x    |     |     |     |      | x       | Ļ             | 1    |
| Whitman      |      | x    |     |     |     |      |         | Ļ             | 1    |
| Yakima       |      | x    | x   |     |     |      | x       | →             | 2    |

### State Agency Resources Allocated to Counties 2015

Notes: (a list of acronyms can be found in Appendix - List of Agencies Acronyms and Abbreviations on page 53)

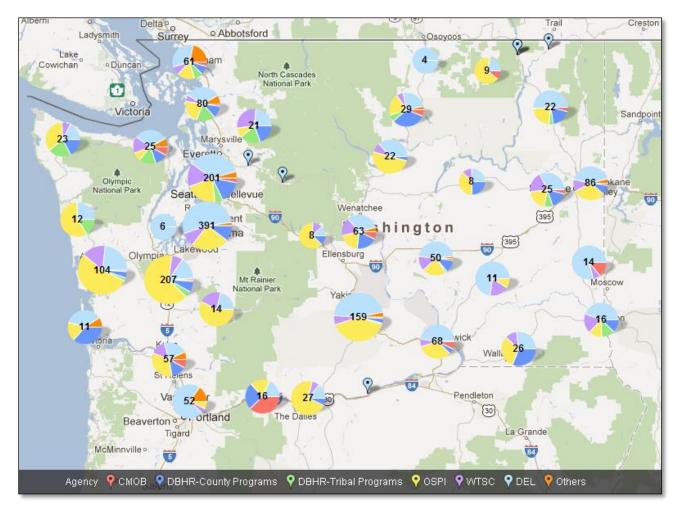
- CMOB county allocations
- DBHR county allocations for prevention services/CPWI (not WHY or other special grants)
- DEL county allocations for ESIT (special programs not indicated NFP/Home visiting)
- DOH Local Health Jurisdictions
- WSP target zero
- WTSC task forces
- NW HIDTA federal funding allocated to counties

**Resources - Figure 3** 



# Prevention Programs by Agency/Organization

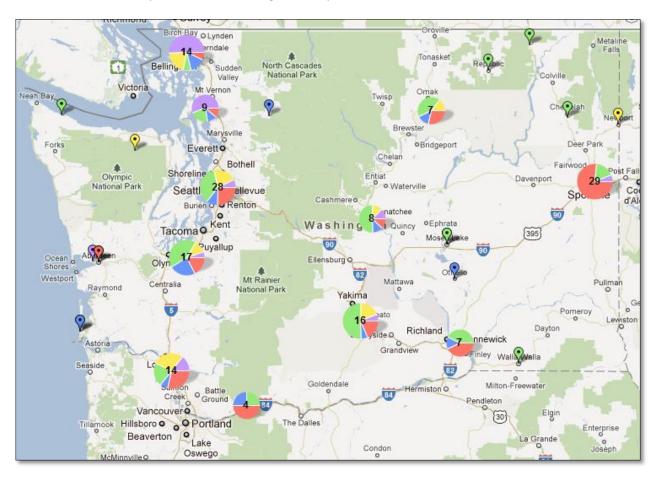
\*This section was not updated in the Strategic Plan Update for 2015



- CMOB direct service programs and coalitions
- DBHR Tribal Programs
- DBHR –County Programs direct service programs and coalitions
- **OSPI** P/I Services and 21<sup>st</sup> Century sites
- WSTC Corridor safety programs; DUI Enforcement Campaign; HS Distracted Driving projects; and Click It or Ticket projects
- **DEL** ECEAP/Head Start
- DOH (other) Community Transformation grant programs
- DFC (other) project sites [federal only]
- AGO(other) Cy Pres Funds for mental health programs
- **PSCB** (other) SAPS Trainings

# **Coalitions by Agency/Organization**

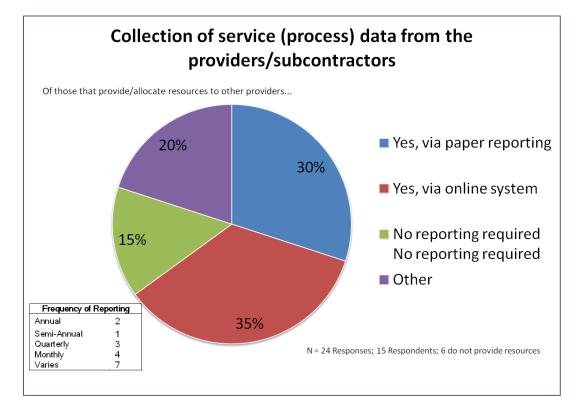
\*This section was not updated in the Strategic Plan Update for 2015

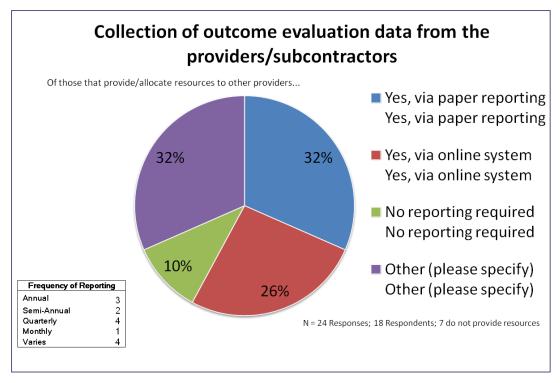


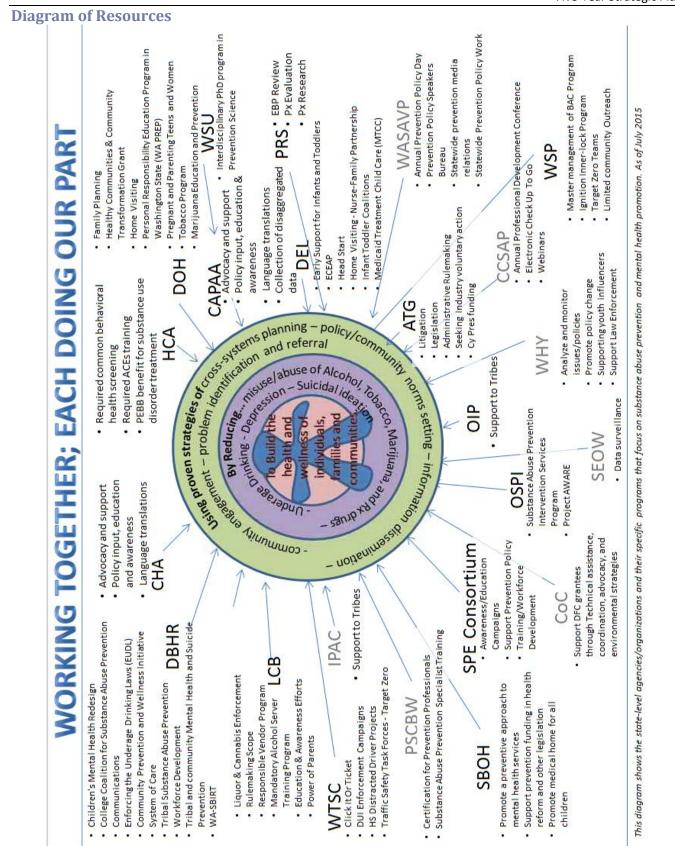
- CMOB Coalitions
- DBHR PRI Coalitions
- **OSPI** –21<sup>st</sup> Century consortiums
- DFC Project sites [federal only]
- DOH Community Transformation grant coalitions

### **Collection of Evaluation Data**

\*This section not completed for the Strategic Plan Update 2015

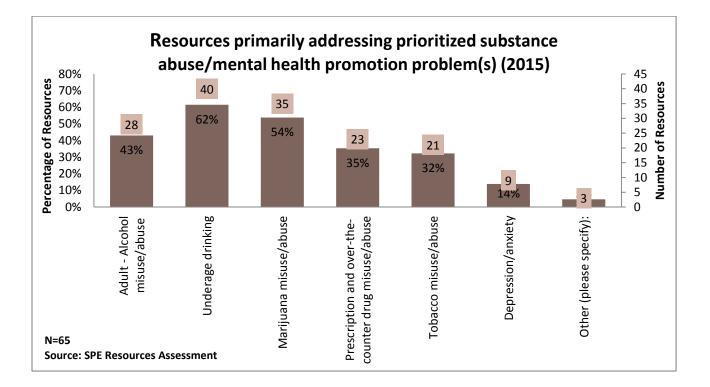


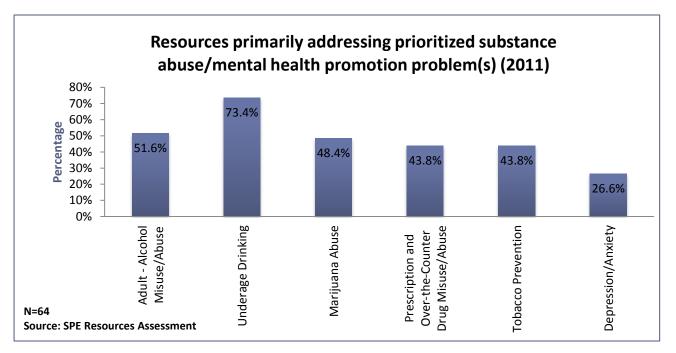




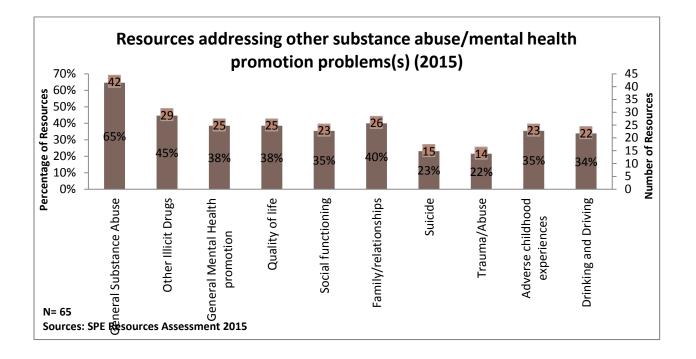
Page **105** of **130** 

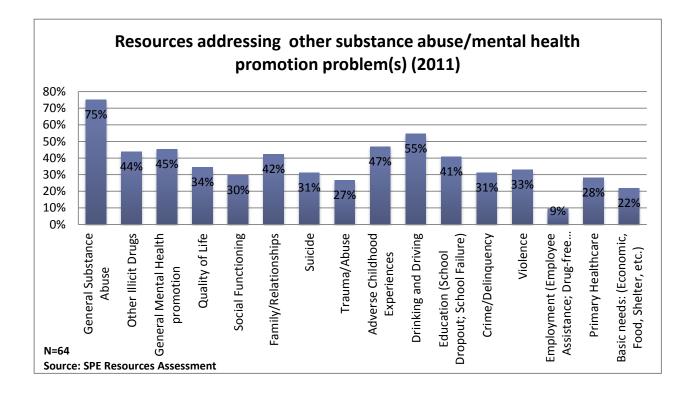
### Summary of Resource Information<sup>26</sup>



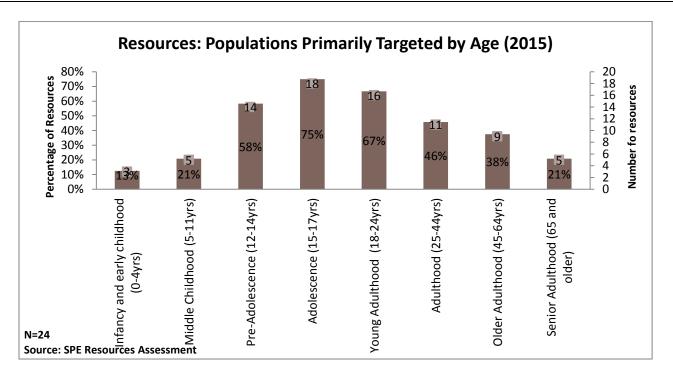


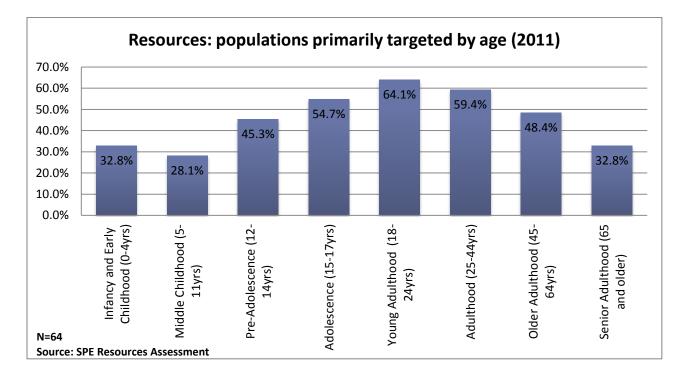
<sup>&</sup>lt;sup>26</sup> Resources may be duplicated as agencies were allowed to select more than one area, therefore category totals will equal more than 100 percent if combined.



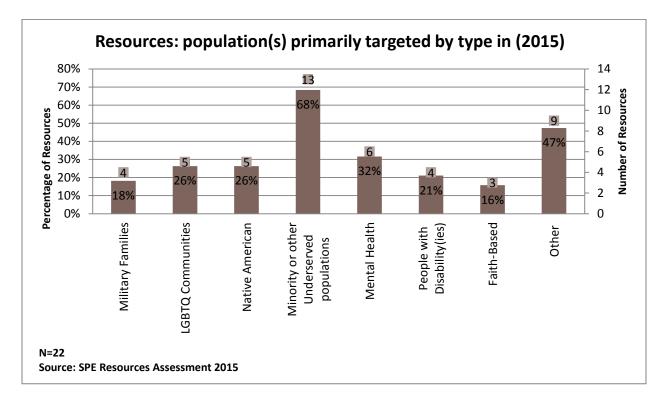


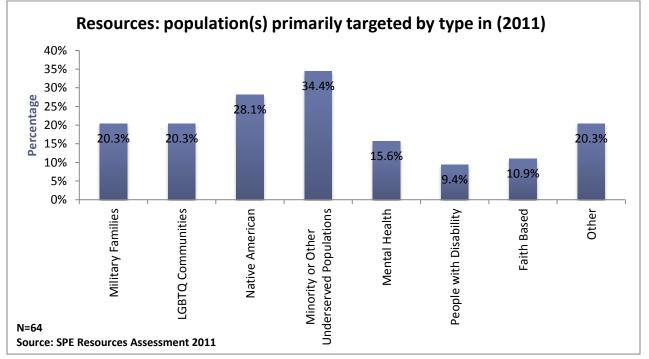
Page 107 of 130



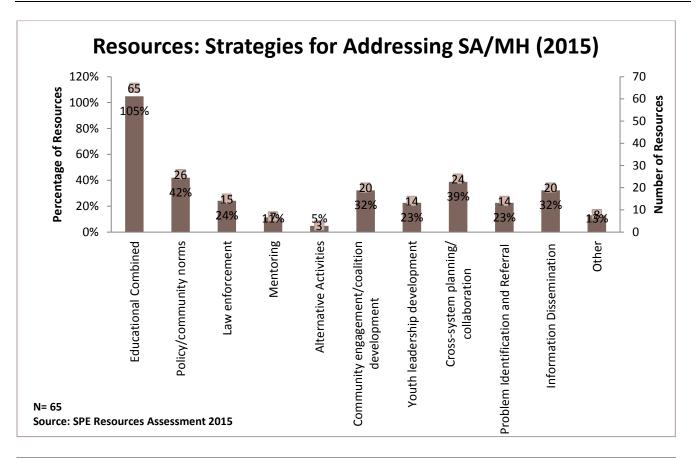


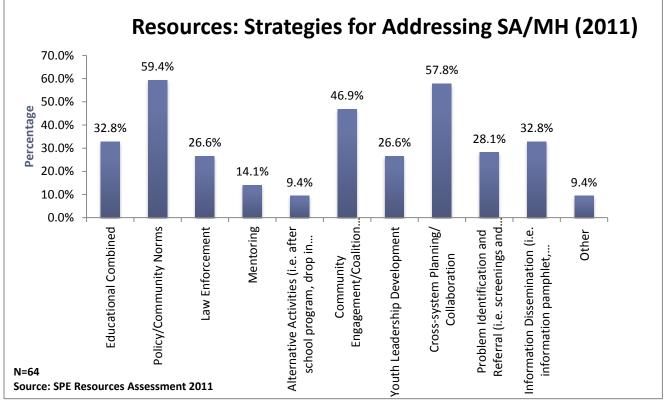
Page 108 of 130





Page 109 of 130





Page 110 of 130

# Matrix of Resources Identified in Resource Assessment focused on Substance Abuse (\*) Represents no new data in 2015.

| Resources Focused on Substance Abuse       AGO - Legislation, Administrative Rulemaking, And Seeking Industry Voluntary Action         CCSAP - Webinars       x         CCSAP - Webinars       x         CCSAP - Year End Professional Development Conference       x         CCSAP - Electronic Check Up To Go       x         CoC - Federal Drug Free Communities Support Program       x         DBHR - Community Prevention and Wellness Initiative       x         DBHR - Children's Mental Health Redesign       x         DBHR - Tribal Substance Abuse Prevention       x         DBHR - Enforcing The Underage Drinking Laws (EUDL)       DBHR - College Coalition For Substance Abuse Prevention         DBHR - WASBIRT-PCI       x         DBHR - Washington Healthy Youth Coalition       x | 3   | x ::<br>x ::<br>x ::<br>x ::<br>x ::<br>x ::<br>x ::<br>x :: | x x x x x x x x x x x x x x x x x x x | x x x x x x x x x x x x x x x x x x x | x<br>x<br>x<br>x<br>x<br>x<br>x<br>x | x x x x x x x x x x x x x x x x x x x | x<br>x<br>Other Illicit Drugs | x<br>x<br>Drinking and Driving |
|---|---|--|---------------------------------------|---------------------------------------|--------------------------------------|---------------------------------------|-------------------------------|--------------------------------|
| AGO - Legislation, Administrative Rulemaking, And Seeking Industry Voluntary Action         CCSAP - Webinars       x         CCSAP - Year End Professional Development Conference       x         CCSAP - Electronic Check Up To Go       x         CoC - Federal Drug Free Communities Support Program       x         DBHR - Community Prevention and Wellness Initiative       x         DBHR - Children's Mental Health Redesign       x         DBHR - Tribal Substance Abuse Prevention       x         DBHR - College Coalition For Substance Abuse Prevention       x         DBHR - College Coalition For Substance Abuse Prevention       x   | 3   | x : : : : : : : : : : : : : : : : : : :                      | x x x x x x x x x x x x x x x x x x x | x x x x x x x x x x x x x x x x x x x | x<br>x<br>x<br>x<br>x<br>x<br>x      | x x x x x x x x x x x x x x x x x x x | x<br>x<br>x<br>x              | x<br>x<br>x<br>x<br>x<br>x     |
| CCSAP - Year End Professional Development Conference       x         CCSAP - Electronic Check Up To Go       x         CoC - Federal Drug Free Communities Support Program       x         DBHR - Community Prevention and Wellness Initiative       x         DBHR - Children's Mental Health Redesign       x         DBHR - Tribal Substance Abuse Prevention       x         DBHR - Enforcing The Underage Drinking Laws (EUDL)       DBHR - College Coalition For Substance Abuse Prevention         DBHR - WASBIRT-PCI       x  | د<br>د<br>د<br>د<br>د<br>د<br>د<br>د<br>د<br>د<br>د<br>د<br>د<br>د<br>د<br>د<br>د<br>د<br>د | x : : : : : : : : : : : : : : : : : : :                      | x x x x x x x x x x x x x x x x x x x | x x x x x x x x x x x x x x x x x x x | x<br>x<br>x<br>x<br>x                | x<br>x<br>x<br>x                      | x<br>x<br>x                   | x<br>x<br>x<br>x               |
| CCSAP - Electronic Check Up To Go       x         CoC - Federal Drug Free Communities Support Program       x         DBHR - Community Prevention and Wellness Initiative       x         DBHR - Children's Mental Health Redesign       x         DBHR - Tribal Substance Abuse Prevention       x         DBHR - Enforcing The Underage Drinking Laws (EUDL)       DBHR - College Coalition For Substance Abuse Prevention         X       DBHR - College Coalition For Substance Abuse Prevention       x  | 3<br>3<br>3<br>3<br>3<br>3<br>3<br>3<br>3<br>3<br>3<br>3<br>3<br>3<br>3<br>3<br>3<br>3<br>3 | x ::<br>x ::<br>x ::<br>x ::<br>x ::<br>x ::<br>x ::<br>x :: | x x x x x x x x x x x x x x x x x x x | x<br>x<br>x<br>x                      | x<br>x<br>x<br>x                     | x<br>x<br>x                           | x<br>x<br>x                   | x<br>x<br>x                    |
| CoC - Federal Drug Free Communities Support Program       x         DBHR - Community Prevention and Wellness Initiative       x         DBHR - Children's Mental Health Redesign       x         DBHR - Tribal Substance Abuse Prevention       x         DBHR - Enforcing The Underage Drinking Laws (EUDL)       DBHR - College Coalition For Substance Abuse Prevention         DBHR - WASBIRT-PCI       x   | 3   | x : : : : : : : : : : : : : : : : : : :                      | x<br>x<br>x<br>x<br>x<br>x            | x<br>x<br>x                           | x<br>x<br>x<br>x                     | x<br>x<br>x                           | x                             | x<br>x                         |
| DBHR - Community Prevention and Wellness Initiative       x         DBHR - Children's Mental Health Redesign       x         DBHR - Tribal Substance Abuse Prevention       x         DBHR - Enforcing The Underage Drinking Laws (EUDL)       DBHR - College Coalition For Substance Abuse Prevention         DBHR - WASBIRT-PCI       x   | 3   | x ::<br>x ::<br>x ::<br>x ::<br>x ::<br>x ::                 | x<br>x<br>x<br>x<br>x                 | x<br>x<br>x                           | x<br>x<br>x                          | x<br>x                                | x                             | x                              |
| DBHR - Children's Mental Health Redesign       x         DBHR - Tribal Substance Abuse Prevention       x         DBHR - Enforcing The Underage Drinking Laws (EUDL)       DBHR - College Coalition For Substance Abuse Prevention         DBHR - WASBIRT-PCI       x   | ر<br>د<br>د<br>د  | x : :<br>x : :<br>x : :<br>x : :                             | x<br>x<br>x<br>x                      | x<br>x<br>x                           | x<br>x                               | x                                     | x                             |                                |
| DBHR - Tribal Substance Abuse Prevention       x         DBHR - Enforcing The Underage Drinking Laws (EUDL)       DBHR - College Coalition For Substance Abuse Prevention         DBHR - WASBIRT-PCI       x  | :<br>:<br>:<br>:  | x :<br>x :<br>x :<br>x :<br>x                                | x<br>x<br>x                           | x<br>x                                | x                                    |                                       |                               | x                              |
| DBHR - Enforcing The Underage Drinking Laws (EUDL)         DBHR - College Coalition For Substance Abuse Prevention       x         DBHR - WASBIRT-PCI       x   | :<br>:<br>:<br>:  | x :<br>x :<br>x :<br>x :                                     | x                                     | x                                     |                                      |                                       |                               | x                              |
| DBHR - College Coalition For Substance Abuse Prevention     x       DBHR - WASBIRT-PCI     x  |   | x :<br>x<br>x  | x                                     |                                       | x                                    | x                                     |                               |                                |
| DBHR – WASBIRT-PCI x  | 1   | x<br>x   |                                       |                                       | x                                    | x                                     |                               | x                              |
| DBHR – WASBIRT-PCI x  | 1   | x  |                                       | x                                     |                                      |                                       | х                             | x                              |
|   | 1   | x  |                                       |                                       | х                                    | x                                     | x                             | x                              |
|   |   |  | х                                     | x                                     |                                      |                                       | x                             | x                              |
| DBHR - Workforce Development x  |   | X I  |                                       | x                                     | x                                    | x                                     | x                             | x                              |
| DBHR - Communications x   | 2   |  |                                       | x                                     |                                      | x                                     | x                             | x                              |
| DBHR - Prevention Research Subcommittee x   |   |  |                                       | x                                     |                                      | x                                     | x                             | x                              |
| DEL - Home Visiting Programs x  | -   |  |                                       | ^                                     | ~                                    | ^                                     | ~                             | ~                              |
| DEL - Head Start x  |   |  |                                       |                                       |                                      |                                       |                               |                                |
| DEL - Early Support For Infants And Toddlers x  |   |  |                                       |                                       |                                      |                                       |                               |                                |
| DEL - ECEAP- Early Childhood Education Economic Assistance Program State Preschool  |   |  |                                       |                                       |                                      |                                       |                               |                                |
| DEL - Medicaid Treatment Child Care Program x   |   |  |                                       |                                       |                                      |                                       | x                             |                                |
|   |   |  |                                       |                                       |                                      | ~                                     | <u> </u>                      |                                |
| DOH – Youth Tobacco Program   |   |  |                                       | x                                     |                                      | x                                     |                               |                                |
| DOH - Youth Suicide Prevention Program  |   |  | x                                     | x                                     | x                                    |                                       |                               |                                |
| DOH - Home Visiting* x  |   |  |                                       |                                       |                                      |                                       |                               |                                |
| DOH - Coordinated School Health Program* x  |   |  |                                       |                                       |                                      |                                       |                               |                                |
| DOH - Healthy Communities & Community Transformation Grant*   |   |  |                                       |                                       |                                      | x                                     |                               |                                |
| DOH - Family Planning* x  |   |  |                                       |                                       |                                      |                                       |                               | x                              |
| HCA - Service   |   |  |                                       |                                       | x                                    |                                       |                               |                                |
| HCA – Smoking Cessation   |   |  |                                       |                                       |                                      |                                       |                               |                                |
| HCA-SBIRT Screening   |   |  |                                       |                                       |                                      |                                       |                               |                                |
| HCA – Triple PPP  |   |  |                                       |                                       |                                      |                                       |                               |                                |
| HCA - Required Common Behavioral Health Screening Guideline Across All Managed Care   | 1   | x  |                                       | x                                     | x                                    |                                       | x                             |                                |
| Organizations.  |   |  |                                       |                                       |                                      |                                       |                               |                                |
| HCA - Required Training On Adverse Childhood Experiences For The Primary Care Provider  | 1   | x  | x                                     | x                                     | x                                    | x                                     | x                             |                                |
| Community In The State Of Washington.   |   |  |                                       |                                       |                                      |                                       |                               |                                |
| HCA - PEBB Benefit For Substance Use Disorder Treatment x   |   | x  |                                       | x                                     | x                                    |                                       | x                             |                                |
| IPAC - Support Tribes x   |   |  |                                       | x                                     | x                                    | x                                     | x                             |                                |
| LCB – Technical Assistance and Education x  | 1   |  | x                                     |                                       |                                      |                                       |                               |                                |
| LCB - Power Of Parents  |   | :  | x                                     |                                       |                                      |                                       |                               |                                |
| LCB - Liquor Enforcement x  | 3   | <b>x</b>   | x                                     |                                       |                                      |                                       |                               | x                              |

| Resources Focused on Substance Abuse                            | General Substance<br>Abuse | Adult - Alcohol<br>misuse/abuse | Underage drinking | Marijuana abuse | Prescription and over-<br>the-counter drug<br>misuse/abuse | Tobacco prevention | Other Illicit Drugs | Drinking and Driving |
|---|----------------------------|---------------------------------|-------------------|-----------------|--|--------------------|---------------------|----------------------|
| LCB - Rulemaking Scope  | x                          | x                               |                   |                 |  |                    |                     |                      |
| LCB - Responsible Vendor Program                                | x                          | x                               | x                 |                 |  |                    | x                   | x                    |
| LCB - Mandatory Alcohol Server Training Program                 | x                          | x                               | x                 |                 |  |                    |                     |                      |
| LCB - Education And Awareness Efforts – Printed Materials       | x                          |                                 | x                 | x               |  |                    |                     |                      |
| OIP - Support Tribes  | x                          | x                               | x                 | x               | x  | x                  | x                   |                      |
| OSPI - Substance Abuse Prevention Intervention Services Program | х                          |                                 | х                 | Х               | x  | х                  | x                   |                      |
| OSPI – Project Aware  |                            |                                 |                   |                 |  |                    |                     |                      |
| PSCBW - Certification For Prevention Professionals              | x                          | x                               | x                 | x               | x  | x                  | x                   | x                    |
| PSCBW - Substance Abuse Prevention Specialist Training          | x                          | x                               | x                 | x               | x  | x                  | x                   | x                    |
| SEOW - Data Surveillance  | x                          | x                               | X                 | x               | x  | x                  | x                   |                      |
| WASAVP - Annual Prevention Policy Day                           | x                          |                                 | x                 | X               | x  | x                  |                     |                      |
| WASAVP - Statewide Prevention Policy Work                       | x                          |                                 | x                 | X               | x  | x                  |                     | x                    |
| WASAVP - Statewide Prevention Medial Relations                  | x                          |                                 | x                 | x               | x  | x                  | x                   | x                    |
| WASAVP - Prevention Policy Speakers Bureau                      | x                          |                                 | x                 | x               | x  | x                  | х                   |                      |
| WHY – Law Enforcement Partnerships                              | x                          | x                               | x                 |                 |  |                    |                     |                      |
| WHY – Let's Draw the Line Between Youth and Alcohol             | x                          | x                               | x                 | x               |  |                    | x                   | x                    |
| WHY – Media Awareness Presentations with Miss Washington        | x                          |                                 | x                 | x               |  |                    | x                   | x                    |
| WHY - Analyze And Monitor Issues/Policies                       | x                          |                                 | x                 |                 |  |                    |                     | x                    |
| WHY - Promote Policy Change                                     | x                          |                                 | x                 |                 |  |                    |                     | x                    |
| WHY - Supporting Youth Influencers                              | x                          |                                 | x                 |                 |  |                    |                     | x                    |
| WHY - Support Law Enforcement                                   | x                          |                                 | x                 |                 |  |                    |                     | x                    |
| WSP - Ignition Inner-Lock Program                               | x                          | x                               |                   |                 |  |                    |                     | x                    |
| WSP - Target Zero Teams   | X                          | x                               | x                 | x               | x  |                    | x                   | X                    |
| WSU - Interdisciplinary PhD Program In Prevention Science       | x                          | x                               | x                 | x               | x  | x                  | x                   | x                    |
| WTSC - Click It or Ticket                                       | x                          | x                               | x                 |                 |  |                    |                     | x                    |
| WTSC - HS Distracted Driver Projects                            |                            |                                 | x                 |                 |  |                    |                     | x                    |
| WTSC - DUI Enforcement Campaigns                                |                            | x                               | x                 |                 |  |                    |                     | x                    |
| WTSC - Traffic Safety Task Forces - Target Zero                 |                            |                                 | x                 |                 |  |                    |                     | x                    |
|   |                            |                                 |                   |                 |  |                    |                     |                      |

### Matrix of Resources Identified in Resource Assessment focused on Mental Health

| Resources focused on Mental Health       Image: Community Prevention and Wellness Initiative         DBHR - Community Prevention and Wellness Initiative       x         DBHR - Children's Mental Health Redesign       x         DBHR - College Coalition For Substance Abuse Prevention       x         DBHR - Communications       x         DBHR - Forevention Research Subcommittee       V         DBH - Forevention Research Subcommittee       X         DBL - Head Start       x         DEL - Early Support For Infants And Toddlers       X         DEL - Head Start       x         DEL - Medication Treatment Child Care Program       X         DOH - Tobacco Youth Prevention Program       X         DOH - Tobacco Youth Prevention Program       X         DOH - Sulf DE PREVENTION WORKSI       X         DOH - Home Visi   | x x x x x x x x x x x x x x x x x x x | x x x x x x x         | × × × × × Family/<br>Relationships | x<br>x<br>x<br>x | × × × Trauma/Abuse | x Adverse<br>Childhood<br>Experiences |
|--|---------------------------------------|-----------------------|------------------------------------|------------------|--------------------|---------------------------------------|
| DBHR - Children's Mental Health Redesign       x         DBHR - Tribal Substance Abuse Prevention       x         DBHR - College Coalition For Substance Abuse Prevention       x         DBHR - WASBIRT - PCI       x         DBHR - WASBIRT - PCI       x         DBHR - Washington Healthy Youth Coalition       x         DBHR - Workforce Development       x         DBHR - Communications       x         DBH - Frevention Research Subcommittee       x         DEL - Infant Toddler Regions       x         DEL - Head Start       x         DEL - Head Start       x         DEL - EcEAP- Early Childhood Education Economic Assistance Program State Preschool       x         DEL - Hedicial Treatment Child Care Program       x         DDH - Tobacco Youth Prevention Program       x         DDH - Tobacco Youth Prevention Program       x         DOH - SUICIDE PREVENTION WORKS!       x         DOH - SUICIDE PREVENTION WORKS!       x         DOH - Forigrant And Parenting Teens And Women       x         DOH - Pregnant And Parenting Teens And Women       x         DOH - Fersonal Responsibility Education Program in Washington State (WA PREP)       x         DOH - Ferming Densive Systems Grant *       x         DOH - Fereinity Communities & Community Tr  | x<br>x<br>x<br>x<br>x<br>x<br>x<br>x  | x<br>x<br>x<br>x<br>x | X<br>X<br>X<br>X                   | x<br>x           | x                  | x                                     |
| DBHR - Tribal Substance Abuse Prevention       x         DBHR - College Coalition For Substance Abuse Prevention       x         DBHR - Washington Healthy Youth Coalition       x         DBHR - Washington Healthy Youth Coalition       x         DBHR - Workforce Development       x         DBHR - Communications       x         DBHR - Communications       x         DEL - Infant Toddler Regions       x         DEL - Home Visiting Programs       x         DEL - Head Start       x         DEL - Early Support For Infants And Toddlers       x         DEL - Early Support For Infants And Toddlers       x         DEL - Early Support For Infants And Toddlers       x         DEL - Early Support For Infants And Toddlers       x         DEL - Early Schildhood Education Economic Assistance Program State Preschool       x         DEL - Medicial Treatment Child Care Program       x         DOH - Tobacco Youth Prevention Program       x         DOH - SUICIDE PREVENTION WORKS1       x         DOH - Home Visiting*       x         DOH - Cordinated School Health Program In Washington State (WA PREP)       x         DOH - Coordinated School Health Program In Washington State (WA PREP)       x         DOH - Pregnant And Parenting Teens And Women       x <t< td=""><td>x<br/>x<br/>x<br/>x<br/>x<br/>x<br/>x<br/>x</td><td>x<br/>x<br/>x<br/>x<br/>x</td><td>x<br/>x<br/>x</td><td>x<br/>x</td><td>x</td><td></td></t<> | x<br>x<br>x<br>x<br>x<br>x<br>x<br>x  | x<br>x<br>x<br>x<br>x | x<br>x<br>x                        | x<br>x           | x                  |                                       |
| DBHR - College Coalition For Substance Abuse Prevention       x         DBHR - WASBIRT - PCI       x         DBHR - Washington Healthy Youth Coalition       x         DBHR - Workforce Development       x         DBHR - Communications       x         DBHR - Prevention Research Subcommittee       x         DEL - Infant Toddler Regions       x         DEL - Home Visiting Programs       x         DEL - Head Start       x         DEL - Early Support For Infants And Toddlers       x         DEL - Early Childhood Education Economic Assistance Program State Preschool       x         DEL - Medicaid Treatment Child Care Program       x         DDH - Tobacco Youth Prevention Program       x         DOH - SuicIDE PREVENTION WORKS1       x         DOH - Project Launch Grant*       x         DOH - Home Visiting*       x         DOH - Fersonal Responsibility Education Program In Washington State (WA PREP)       DOH - Pregnant And Parenting Teens And Women         DOH - Family Planning       x         DOH - Family Planning       x         HCA - Required Common Behavioral Health Screening Guideline Across All Managed Care Organizations.       x         HCA - Required Common Behavioral Health Screening Guideline Across All Managed Care Corganizations.       x         HCA - Requ   | x<br>x<br>x<br>x<br>x<br>x            | x<br>x<br>x<br>x      | x<br>x                             | x                |                    | x                                     |
| DBHR - WASBIRT - PCI       x         DBHR - Washington Healthy Youth Coalition       x         DBHR - Workforce Development       x         DBHR - Communications       x         DBHR - Prevention Research Subcommittee       x         DEL - Infant Toddler Regions       x         DEL - Home Visiting Programs       x         DEL - Head Start       x         DEL - Early Support For Infants And Toddlers       x         DEL - Early Childhood Education Economic Assistance Program State Preschool       x         DEL - Medicaid Treatment Child Care Program       x         DDH - Tobacco Youth Prevention Program       x         DOH - Tobacco Youth Prevention Program       x         DOH - SUICIDE PREVENTION WORKS1       x         DOH - Project Launch Grant*       x         DOH - Home Visiting*       x         DOH - Fersonal Responsibility Education Program In Washington State (WA PREP)       DOH - Pergnant And Parenting Teens And Women         DOH - Pergnant And Parenting Teens And Women       X         DOH - Family Planning       x         HCA - Required Common Behavioral Health Screening Guideline Across All Managed Care       x         OPH - Family Planning       x         HCA - Required Common Behavioral Health Screening Guideline Across All Managed Care <t< td=""><td>x<br/>x<br/>x<br/>x<br/>x<br/>x</td><td>x<br/>x<br/>x</td><td>x</td><td></td><td>х</td><td></td></t<>                           | x<br>x<br>x<br>x<br>x<br>x            | x<br>x<br>x           | x                                  |                  | х                  |                                       |
| DBHR - Washington Healthy Youth Coalition         DBHR - Communications       x         DBHR - Communications       x         DBHR - Prevention Research Subcommittee  | x<br>x<br>x<br>x                      | x                     |                                    | X                |                    | x                                     |
| DBHR - Workforce Development       x         DBHR - Communications       x         DBHR - Prevention Research Subcommittee   | x<br>x<br>x                           | x                     | x                                  |                  | x                  |                                       |
| DBHR - Communications       x         DBHR - Prevention Research Subcommittee  | x<br>x                                |                       |                                    |                  | x                  | x                                     |
| DBHR - Prevention Research Subcommittee         DEL - Infant Toddler Regions       x         DEL - Home Visiting Programs       x         DEL - Head Start       x         DEL - Early Support For Infants And Toddlers       x         DEL - Early Support For Infants And Toddlers       x         DEL - Early Support For Infants And Toddlers       x         DEL - Medicaid Treatment Child Care Program       x         DOH - Tobacco Youth Prevention Program       x         DOH - Tobacco Youth Prevention Program       x         DOH - SUICIDE PREVENTION WORKS1       x         DOH - Home Visiting*       x         DOH - Home Visiting*       x         DOH - Children With Special Health Care Needs*       x         DOH - Personal Responsibility Education Program In Washington State (WA PREP)       DOH - Pregnant And Parenting Teens And Women         DOH - Coordinated School Health Program       x         DOH - Family Planning       x         HCA - Required Common Behavioral Health Screening Guideline Across All Managed Care Organizations.       x         HCA - Required Training On Adverse Childhood Experiences       x         IPAC - Support Tribes       x         ICB - Power Of Parents       V         OIP - Support Tribes       x  | x<br>x                                |                       |                                    |                  |                    | x                                     |
| DEL - Infant Toddler Regions       x         DEL - Home Visiting Programs       x         DEL - Head Start       x         DEL - Early Support For Infants And Toddlers       x         DEL - Early Support For Infants And Toddlers       x         DEL - EcRAP- Early Childhood Education Economic Assistance Program State Preschool       x         DEL - Medicaid Treatment Child Care Program       x         DOH - Tobacco Youth Prevention Program       x         DOH - Tobacco Youth Prevention Program       x         DOH - SUICIDE PREVENTION WORKS!       x         DOH - Project Launch Grant*       x         DOH - Home Visiting*       x         DOH - Childrond Comprehensive Systems Grant*       x         DOH - Children With Special Health Care Needs*       x         DOH - Pregnant And Parenting Teens And Women       DOH - Pregnant And Parenting Teens And Women         DOH - Family Planning       x         HCA - Required Common Behavioral Health Screening Guideline Across All Managed Care or organizations.       x         HCA - Required Training On Adverse Childhood Experiences       x         LCB - Power Of Parents       OIP - Support Tribes       x  | x                                     | x                     | х                                  | x                | x                  | x                                     |
| DEL - Home Visiting Programs       x         DEL - Head Start       x         DEL - Early Support For Infants And Toddlers       x         DEL - Early Childhood Education Economic Assistance Program State Preschool       x         DEL - Medicaid Treatment Child Care Program       x         DDH - Tobacco Youth Prevention Program       x         DOH - Tobacco Youth Prevention Program       x         DOH - Tobacco Youth Prevention Program       x         DOH - SUICIDE PREVENTION WORKS1       x         DOH - Project Launch Grant*       x         DOH - Home Visiting*       x         DOH - Children With Special Health Care Needs*       x         DOH - Personal Responsibility Education Program In Washington State (WA PREP)       DOH - Pregnant And Parenting Teens And Women         DOH - Coordinated School Health Program       x       X         DOH - Family Planning       x       X         HCA - Required Common Behavioral Health Screening Guideline Across All Managed Care Organizations.       x         HCA - Required Training On Adverse Childhood Experiences       x         IPAC - Support Tribes       x         UCB - Power Of Parents       OIP - Support Tribes       x   |                                       |                       | x                                  | x                | x                  | x                                     |
| DEL - Head Start       x         DEL - Early Support For Infants And Toddlers       x         DEL - ECEAP- Early Childhood Education Economic Assistance Program State Preschool       x         DEL - Medicaid Treatment Child Care Program       x         DOH - Tobacco Youth Prevention Program       x         DOH - Tobacco Youth Prevention Program       x         DOH - SUICIDE PREVENTION WORKS!       x         DOH - SUICIDE PREVENTION WORKS!       x         DOH - Forject Launch Grant*       x         DOH - Early Childhood Comprehensive Systems Grant*       x         DOH - Children With Special Health Care Needs*       x         DOH - Presonal Responsibility Education Program In Washington State (WA PREP)       DOH - Pregnant And Parenting Teens And Women         DOH - Coordinated School Health Program       x         DOH - Family Planning       x         HCA - Required Common Behavioral Health Screening Guideline Across All Managed Care Organizations.       x         HCA - Required Training On Adverse Childhood Experiences       x         LCB - Power Of Parents       X         OIP - Support Tribes       x  | x                                     | x                     | x                                  |                  | x                  | x                                     |
| DEL - Early Support For Infants And Toddlers       x         DEL - ECEAP- Early Childhood Education Economic Assistance Program State Preschool       x         DEL - Medicaid Treatment Child Care Program       x         DOH - Tobacco Youth Prevention Program       x         DOH - SUICIDE PREVENTION WORKS!       x         DOH - Project Launch Grant*       x         DOH - Home Visiting*       x         DOH - Early Childhood Comprehensive Systems Grant*       x         DOH - Children With Special Health Care Needs*       x         DOH - Presonal Responsibility Education Program In Washington State (WA PREP)       DOH - Pregnant And Parenting Teens And Women         DOH - Coordinated School Health Program       x         DOH - Family Planning       x         HCA - Required Common Behavioral Health Screening Guideline Across All Managed Care Organizations.       x         HCA - Required Training On Adverse Childhood Experiences       x         LCB - Power Of Parents       X         OIP - Support Tribes       x  |                                       | x                     | x                                  |                  |                    | x                                     |
| DEL - ECEAP- Early Childhood Education Economic Assistance Program State Preschool       x         DEL - Medicaid Treatment Child Care Program       x         DOH - Tobacco Youth Prevention Program       x         DOH - Youth Suicide Prevention Program       x         DOH - SUICIDE PREVENTION WORKS!       x         DOH - Project Launch Grant*       x         DOH - Home Visiting*       x         DOH - Home Visiting*       x         DOH - Childhood Comprehensive Systems Grant*       x         DOH - Children With Special Health Care Needs*       x         DOH - Pregnant And Parenting Teens And Women       DOH - Coordinated School Health Program         DOH - Family Planning       x         HCA - Required Common Behavioral Health Screening Guideline Across All Managed Care Organizations.       x         HCA - Required Training On Adverse Childhood Experiences       x         LCB - Power Of Parents       x         OIP - Support Tribes       x  | x                                     | x                     | x                                  |                  | x                  | x                                     |
| DEL - Medicaid Treatment Child Care Program       x         DOH - Tobacco Youth Prevention Program       x         DOH - Youth Suicide Prevention Program       x         DOH - SUICIDE PREVENTION WORKS!       x         DOH - Project Launch Grant*       x         DOH - Home Visiting*       x         DOH - Early Childhood Comprehensive Systems Grant*       x         DOH - Children With Special Health Care Needs*       x         DOH - Personal Responsibility Education Program In Washington State (WA PREP)       DOH - Pregnant And Parenting Teens And Women         DOH - Coordinated School Health Program       x         DOH - Family Planning       x         HCA - Required Common Behavioral Health Screening Guideline Across All Managed Care Organizations.       x         HCA - Required Training On Adverse Childhood Experiences       x         LCB - Power Of Parents       x         OIP - Support Tribes       x  | x                                     | x                     | x                                  |                  |                    | x                                     |
| DOH - Tobacco Youth Prevention Program       x         DOH - Youth Suicide Prevention Program       x         DOH - SUICIDE PREVENTION WORKS!       x         DOH - Project Launch Grant*       x         DOH - Home Visiting*       x         DOH - Early Childhood Comprehensive Systems Grant*       x         DOH - Children With Special Health Care Needs*       x         DOH - Personal Responsibility Education Program In Washington State (WA PREP)       DOH - Pergnant And Parenting Teens And Women         DOH - Coordinated School Health Program       x         DOH - Healthy Communities & Community Transformation Grant       x         DOH - Family Planning       x         HCA - Required Common Behavioral Health Screening Guideline Across All Managed Care       x         Organizations.       x         HCA - Required Training On Adverse Childhood Experiences       x         LCB - Power Of Parents       x         OIP - Support Tribes       x   | x                                     | x                     | x                                  |                  |                    |                                       |
| DOH - Youth Suicide Prevention Program       x         DOH - SUICIDE PREVENTION WORKS!       x         DOH - Project Launch Grant*       x         DOH - Home Visiting*       x         DOH - Early Childhood Comprehensive Systems Grant*       x         DOH - Children With Special Health Care Needs*       x         DOH - Personal Responsibility Education Program In Washington State (WA PREP)       DOH - Pregnant And Parenting Teens And Women         DOH - Coordinated School Health Program       x         DOH - Healthy Communities & Community Transformation Grant       x         POH - Family Planning       x         HCA - Required Common Behavioral Health Screening Guideline Across All Managed Care       x         Organizations.       x         HCA - Required Training On Adverse Childhood Experiences       x         LCB - Power Of Parents       x         OIP - Support Tribes       x  | x                                     | x                     | x                                  |                  | x                  |                                       |
| DOH - SUICIDE PREVENTION WORKS!       x         DOH - Project Launch Grant*       x         DOH - Home Visiting*       x         DOH - Early Childhood Comprehensive Systems Grant*       x         DOH - Children With Special Health Care Needs*       x         DOH - Presonal Responsibility Education Program In Washington State (WA PREP)       DOH - Personal Responsibility Education Program In Washington State (WA PREP)         DOH - Pregnant And Parenting Teens And Women       x         DOH - Coordinated School Health Program       x         DOH - Healthy Communities & Community Transformation Grant       x         DOH - Family Planning       x         HCA - Required Common Behavioral Health Screening Guideline Across All Managed Care       x         Organizations.       x         HCA - Required Training On Adverse Childhood Experiences       x         IPAC - Support Tribes       x         OIP - Support Tribes       x  |                                       |                       |                                    |                  |                    |                                       |
| DOH - Project Launch Grant*       x         DOH - Home Visiting*       x         DOH - Early Childhood Comprehensive Systems Grant*       x         DOH - Children With Special Health Care Needs*       x         DOH - Personal Responsibility Education Program In Washington State (WA PREP)       DOH - Personal Responsibility Education Program In Washington State (WA PREP)         DOH - Pregnant And Parenting Teens And Women       Toold - Coordinated School Health Program       x         DOH - Coordinated School Health Program       x       X         DOH - Healthy Communities & Community Transformation Grant       x       X         DOH - Family Planning       x       X         HCA - Required Common Behavioral Health Screening Guideline Across All Managed Care       x         Organizations.       X       X         HCA - Required Training On Adverse Childhood Experiences       x         LCB - Power Of Parents       X         OIP - Support Tribes       X   | x                                     | x                     | x                                  | x                | x                  | x                                     |
| DOH - Home Visiting*       x         DOH - Early Childhood Comprehensive Systems Grant*       x         DOH - Children With Special Health Care Needs*       x         DOH - Personal Responsibility Education Program In Washington State (WA PREP)       x         DOH - Pregnant And Parenting Teens And Women       x         DOH - Coordinated School Health Program       x         DOH - Healthy Communities & Community Transformation Grant       x         DOH - Family Planning       x         HCA - Required Common Behavioral Health Screening Guideline Across All Managed Care       x         Organizations.       x         HCA - Required Training On Adverse Childhood Experiences       x         LCB - Power Of Parents       x         OIP - Support Tribes       x   | x                                     | x                     | x                                  | x                | x                  | x                                     |
| DOH - Early Childhood Comprehensive Systems Grant*       x         DOH - Children With Special Health Care Needs*       x         DOH - Personal Responsibility Education Program In Washington State (WA PREP)       DOH - Pregnant And Parenting Teens And Women         DOH - Pregnant And Parenting Teens And Women       x         DOH - Coordinated School Health Program       x         DOH - Healthy Communities & Community Transformation Grant       x         DOH - Family Planning       x         HCA - Required Common Behavioral Health Screening Guideline Across All Managed Care       x         Organizations.       x         HCA - Required Training On Adverse Childhood Experiences       x         IPAC - Support Tribes       x         LCB - Power Of Parents       x         OIP - Support Tribes       x   | x                                     | x                     | x                                  |                  |                    | x                                     |
| DOH - Early Childhood Comprehensive Systems Grant*       x         DOH - Children With Special Health Care Needs*       x         DOH - Personal Responsibility Education Program In Washington State (WA PREP)       DOH - Pregnant And Parenting Teens And Women         DOH - Pregnant And Parenting Teens And Women       x         DOH - Coordinated School Health Program       x         DOH - Healthy Communities & Community Transformation Grant       x         DOH - Family Planning       x         HCA - Required Common Behavioral Health Screening Guideline Across All Managed Care       x         Organizations.       x         HCA - Required Training On Adverse Childhood Experiences       x         IPAC - Support Tribes       x         LCB - Power Of Parents       x         OIP - Support Tribes       x   | x                                     | x                     | x                                  |                  | x                  | x                                     |
| DOH - Children With Special Health Care Needs*       x         DOH - Personal Responsibility Education Program In Washington State (WA PREP)       DOH - Pregnant And Parenting Teens And Women         DOH - Coordinated School Health Program       x         DOH - Healthy Communities & Community Transformation Grant       x         DOH - Family Planning       x         HCA - Required Common Behavioral Health Screening Guideline Across All Managed Care       x         Organizations.       x         HCA - Required Training On Adverse Childhood Experiences       x         IPAC - Support Tribes       x         OIP - Support Tribes       x  |                                       |                       | x                                  |                  |                    |                                       |
| DOH - Personal Responsibility Education Program In Washington State (WA PREP)         DOH - Pregnant And Parenting Teens And Women         DOH - Coordinated School Health Program       x         DOH - Healthy Communities & Community Transformation Grant       x         DOH - Family Planning       x         HCA - Required Common Behavioral Health Screening Guideline Across All Managed Care       x         Organizations.       x         HCA - Required Training On Adverse Childhood Experiences       x         IPAC - Support Tribes       x         LCB - Power Of Parents       x   |                                       |                       | x                                  |                  |                    |                                       |
| DOH - Pregnant And Parenting Teens And Women         DOH - Coordinated School Health Program       x         DOH - Healthy Communities & Community Transformation Grant       x         DOH - Family Planning       x         HCA - Required Common Behavioral Health Screening Guideline Across All Managed Care       x         Organizations.       x         HCA - Required Training On Adverse Childhood Experiences       x         IPAC - Support Tribes       x         UCB - Power Of Parents       x         OIP - Support Tribes       x  | x                                     | x                     | x                                  |                  |                    | x                                     |
| DOH - Coordinated School Health Program       x         DOH - Healthy Communities & Community Transformation Grant       x         DOH - Family Planning       x         HCA - Required Common Behavioral Health Screening Guideline Across All Managed Care       x         Organizations.       x         HCA - Required Training On Adverse Childhood Experiences       x         IPAC - Support Tribes       x         LCB - Power Of Parents       x         OIP - Support Tribes       x   | ~                                     | ~                     | x                                  |                  | x                  | x                                     |
| DOH - Healthy Communities & Community Transformation Grant       x         DOH - Family Planning       x         HCA - Required Common Behavioral Health Screening Guideline Across All Managed Care       x         Organizations.       x         HCA - Required Training On Adverse Childhood Experiences       x         IPAC - Support Tribes       x         LCB - Power Of Parents       x         OIP - Support Tribes       x   |                                       |                       | x                                  |                  | ^                  | ^                                     |
| DOH - Family Planning     x       HCA - Required Common Behavioral Health Screening Guideline Across All Managed Care     x       Organizations.     x       HCA - Required Training On Adverse Childhood Experiences     x       IPAC - Support Tribes     x       LCB - Power Of Parents     x       OIP - Support Tribes     x  | x                                     |                       | ^                                  |                  |                    | x                                     |
| HCA - Required Common Behavioral Health Screening Guideline Across All Managed Care       x         Organizations.       x         HCA - Required Training On Adverse Childhood Experiences       x         IPAC - Support Tribes       x         LCB - Power Of Parents       x         OIP - Support Tribes       x  |                                       | v                     | v                                  | ~                | v                  |                                       |
| Organizations.         HCA - Required Training On Adverse Childhood Experiences       x         IPAC - Support Tribes       x         LCB - Power Of Parents       x         OIP - Support Tribes       x  | X                                     | X                     | x                                  | X                | x                  | x                                     |
| IPAC - Support Tribes x LCB - Power Of Parents OIP - Support Tribes x  | x                                     | x                     | x                                  | x                | x                  | x                                     |
| LCB - Power Of Parents OIP - Support Tribes x  | x                                     | x                     | x                                  | x                | x                  | x                                     |
| OIP - Support Tribes x   | x                                     |                       |                                    | x                |                    | x                                     |
|  |                                       |                       | x                                  |                  |                    |                                       |
| OSPI - Substance Abuse Prevention Intervention Services Program  | x                                     |                       |                                    | x                |                    | x                                     |
|  |                                       | x                     | x                                  |                  | x                  | x                                     |
| OSPI – Project Aware x   | х                                     | x                     | x                                  | x                | x                  | x                                     |
| PSCBW - Certification for Prevention Professionals x   | x<br>x                                | x                     | x                                  | x                |                    | x                                     |
| SEOW - Data Surveillance x   |                                       |                       |                                    | x                |                    | x                                     |
| WASAVP - Annual Prevention Policy Day  |                                       |                       | x                                  | x                |                    | x                                     |
| WASAVP - Statewide Prevention Policy Work  |                                       |                       |                                    | x                |                    | x                                     |
| WASAVP - Statewide Prevention Medial Relations   |                                       |                       |                                    | x                |                    | x                                     |

Page **113** of **130** 

| Resources focused on Mental Health                                     | General Mental<br>Health promotion | Quality of life | Social functioning | Family/<br>Relationships | Suicide | Trauma/Abuse | Adverse<br>Childhood<br>Experiences |
|--|------------------------------------|-----------------|--------------------|--------------------------|---------|--------------|-------------------------------------|
| WHY – Law Enforcement Partnerships                                     |                                    | x               | x                  | x                        |         |              |                                     |
| WHY – Let's Draw the Line Between Youth and Alcohol                    | x                                  | x               | x                  | x                        |         |              |                                     |
| WHY – Media Awareness Presentations with Miss Washington               |                                    | x               | x                  |                          |         |              |                                     |
| SBOH - Health Disparities Council Behavioral Health Advisory Committee | x                                  |                 |                    |                          |         |              |                                     |
| WSU - Interdisciplinary PhD Program In Prevention Science              | x                                  | x               | x                  | x                        | x       | x            | x                                   |

## Matrix of Resources Identified in Resource Assessment by Strategy

| Resources by Strategy  | Youth Education/Skill<br>building - School based | Youth Education/Skill<br>building - Community | Parent education/family | Other Educational | Policy/community norms | Law enforcement | Mentoring | Alternative Activities | Community engagement/<br>coalition development | Youth leadership<br>development | Problem Identification and<br>Referral | Information Dissemination | Cross-system planning/<br>collaboration |
|--|--|---|-------------------------|-------------------|------------------------|-----------------|-----------|------------------------|--|---------------------------------|--|---------------------------|---|
| AGO - Litigation, Legislation, Administrative Rulemaking, And<br>Seeking Industry Voluntary Action |  |   |                         |                   | x                      |                 |           |                        |  |                                 |  |                           |   |
| CCSAP - Webinars   |  |   |                         | x                 |                        |                 |           |                        |  |                                 |  |                           |   |
| CCSAP - Year End Professional Development Conference   |  |   |                         | x                 |                        |                 |           |                        | x  |                                 |  | x                         |   |
| CoC - Federal Drug Free Communities Support Program  | x  | x   | x                       | x                 | x                      |                 | x         |                        | x  | x                               |  | x                         | x                                       |
| DBHR - System of Care  |  |   | x                       |                   | x                      |                 |           |                        | x  | x                               |  | х                         | x                                       |
| DBHR - Community Prevention and Wellness Initiative  | x  | x   | x                       | x                 | x                      | x               | x         | x                      | x  | x                               | x                                      | x                         | x                                       |
| DBHR - Children's Mental Health Redesign   |  |   |                         |                   | х                      |                 |           |                        | x  |                                 | x                                      |                           | x                                       |
| DBHR - Tribal Substance Abuse Prevention   | x  | x   | x                       | x                 | x                      | x               | х         | x                      | x  | x                               | x                                      | x                         | x                                       |
| DBHR - College Coalition For Substance Abuse Prevention  |  |   | x                       | x                 | x                      | x               | x         |                        |  |                                 | x                                      | x                         | x                                       |
| DBHR – WASBIRT-PCI   |  |   |                         |                   |                        |                 |           |                        |  |                                 | x                                      | x                         |   |
| DBHR – Washington Healthy Youth Coalition  | x  | x   |                         |                   | x                      | x               |           |                        | x  | x                               |  |                           | x                                       |
| DBHR - Workforce Development   |  |   |                         |                   | x                      |                 |           |                        |  |                                 |  | x                         | x                                       |
| DBHR - Communications  |  |   |                         |                   |                        |                 |           |                        |  |                                 |  | x                         |   |
| DBHR - Prevention Research Subcommittee  |  |   |                         |                   |                        |                 |           |                        |  |                                 | x                                      | x                         | x                                       |
| DEL - Infant Toddler Regions   |  |   |                         |                   | x                      |                 | x         |                        | x  |                                 | x                                      |                           | x                                       |
| DEL - Home Visiting Programs   |  | x   | x                       |                   |                        |                 |           |                        |  |                                 |  |                           |   |
| DEL - Early Support For Infants And Toddlers   |  |   | x                       | x                 |                        |                 |           |                        |  |                                 | x                                      |                           |   |
| DEL - ECEAP- Early Childhood Education Economic Assistance   |  |   |                         | x                 |                        |                 |           |                        |  |                                 | x                                      |                           |   |
| Program State Preschool  |  |   |                         |                   |                        |                 |           |                        |  |                                 |  |                           |   |
| DEL - Medicaid Treatment Child Care Program  |  | x   | x                       | x                 |                        | x               | x         |                        |  |                                 | х                                      |                           | x                                       |
| DOH – Youth Tobacco Program  |  |   |                         |                   | x                      |                 |           |                        | x  | x                               |  |                           |   |
| DOH – Youth Suicide Prevention Program*  |  |   |                         |                   | x                      |                 |           |                        | x  |                                 | x                                      | х                         | x                                       |
| DOH – SUICIDE PREVENTION WORKS!*   | x  |   | x                       | x                 | x                      | x               |           |                        | x  |                                 | x                                      | x                         | x                                       |
| DOH - Project Launch Grant*  |  |   | x                       | x                 | x                      |                 |           |                        | x  |                                 | x                                      | x                         | x                                       |
| DOH - Home Visiting*   |  |   | x                       |                   | x                      |                 |           |                        | x  |                                 |  |                           | x                                       |

Page **114** of **130** 

|  |  |   |                         |                   |                        |                 |           |                        |  | 1100                            | , icui s                               | tiute                     | egic Plan                               |
|--|--|---|-------------------------|-------------------|------------------------|-----------------|-----------|------------------------|--|---------------------------------|--|---------------------------|---|
| Resources by Strategy                                    | Youth Education/Skill<br>building - School based | Youth Education/Skill<br>building - Community | Parent education/family | Other Educational | Policy/community norms | Law enforcement | Mentoring | Alternative Activities | Community engagement/<br>coalition development | Youth leadership<br>development | Problem Identification and<br>Referral | Information Dissemination | Cross-system planning/<br>collaboration |
| DOH - Early Childhood Comprehensive Systems Grant*       |  |   |                         |                   |                        |                 |           |                        |  |                                 |  | x                         | x                                       |
| DOH - Children With Special Healthcare Needs*            |  |   | x                       |                   |                        |                 |           |                        |  |                                 | x                                      | x                         | x                                       |
| DOH - Personal Responsibility Education Program In       | x  | x   | x                       | х                 |                        |                 |           |                        | x  | x                               | x                                      |                           | x                                       |
| Washington State (WA PREP)                               |  |   |                         |                   |                        |                 |           |                        |  |                                 |  |                           |   |
| DOH - Pregnant And Parenting Teens And Women*            | x  | x   | x                       |                   | x                      |                 | x         |                        | x  |                                 | x                                      | x                         | x                                       |
| DOH - Coordinated School Health Program*                 |  |   | x                       | х                 | х                      |                 |           |                        | x  |                                 |  |                           | x                                       |
| DOH - Healthy Communities & Community Transformation     |  |   |                         | x                 | x                      |                 | x         | x                      | x  | x                               | x                                      | x                         | x                                       |
| Grant*   |  |   |                         |                   |                        |                 |           |                        |  |                                 |  |                           |   |
| DOH - Family Planning                                    | x  | x   | X                       | x                 |                        | x               |           |                        |  | x                               | x                                      | X                         | x                                       |
| OJJ - Juvenile Detention Alternatives Initiative*        | ^  | ^   | ^                       | ^                 | x                      | x               |           | x                      | x  | ^                               | x                                      | ^                         | x                                       |
|  |  |   |                         |                   | ×                      | ×               |           | ×                      | *  |                                 |  |                           | *                                       |
| HCA - Service  |  |   |                         |                   |                        |                 |           |                        |  |                                 | x                                      |                           |   |
| HCA - Required Common Behavioral Health Screening        |  |   |                         |                   |                        |                 |           |                        |  |                                 | х                                      |                           |   |
| Guideline Across All Managed Care Organizations.         |  |   |                         |                   |                        |                 |           |                        |  |                                 |  |                           |   |
| HCA – Smoking Cessation                                  |  |   |                         |                   |                        |                 |           |                        |  |                                 |  |                           |   |
| HCA – SBIRT Screening                                    |  |   |                         |                   |                        |                 |           |                        |  |                                 |  |                           |   |
| HCA – Triple PPP   |  |   |                         |                   |                        |                 |           |                        |  |                                 |  |                           |   |
| HCA - Required Training On Adverse Childhood Experiences |  |   |                         | x                 |                        |                 |           |                        |  |                                 |  |                           |   |
| HCA - PEBB Benefit For Substance Use Disorder Treatment  |  |   |                         |                   | x                      |                 |           |                        |  |                                 |  |                           |   |
| IPAC - Support Tribes                                    |  |   |                         |                   |                        |                 |           |                        | x  |                                 |  |                           | x                                       |
| LCB - Agency Initiatives                                 |  |   | x                       | х                 | х                      |                 |           |                        |  |                                 |  | х                         |   |
| LCB - Power Of Parents                                   |  |   | x                       |                   |                        |                 |           |                        |  |                                 |  |                           |   |
| LCB - Liquor Enforcement                                 |  |   |                         |                   | х                      | x               |           |                        |  |                                 |  |                           |   |
| LCB - Rulemaking Scope                                   |  |   |                         |                   | x                      |                 |           |                        |  |                                 |  |                           |   |
| LCB - Responsible Vendor Program                         |  |   |                         | х                 | х                      | x               |           |                        |  |                                 |  |                           |   |
| LCB - Mandatory Alcohol Server Training Program          |  |   |                         | x                 | x                      | x               |           |                        |  |                                 |  |                           |   |
| LCB - Education And Awareness Efforts Printed Materials  |  |   | x                       |                   |                        |                 |           |                        |  |                                 |  | x                         |   |
| LCB – Technical Assistance and Education                 |  |   | x                       |                   | x                      |                 |           |                        | x  |                                 |  | ~                         | x                                       |
| OIP - Support Tribes                                     |  |   | ~                       |                   | ~                      |                 |           |                        | x  |                                 |  |                           | x                                       |
| OSPI - Substance Abuse Prevention Intervention Services  | x  |   | x                       |                   | x                      |                 |           |                        | x  | x                               | x                                      |                           | ^                                       |
| Program  | ^  |   | ^                       |                   | ^                      |                 |           |                        | ^  | ^                               | *                                      |                           |   |
|  |  |   |                         |                   |                        |                 |           |                        |  |                                 |  |                           |   |
| OSPI – Project Aware                                     | x  | x   | x                       |                   |                        |                 |           |                        |  |                                 |  |                           |   |
| PSCBW - Certification For Prevention Professionals       |  |   |                         | x                 |                        |                 |           |                        |  |                                 |  |                           |   |
| PSCBW - Substance Abuse Prevention Specialist Training   |  |   |                         | x                 |                        |                 |           |                        |  |                                 |  |                           | x                                       |
| WASAVP - Annual Prevention Policy Day                    |  | x   |                         |                   | х                      |                 |           | x                      | x  | x                               |  |                           | x                                       |
| WASAVP - Statewide Prevention Policy Work                |  |   |                         |                   | х                      |                 |           |                        |  |                                 |  | х                         |   |
| WASAVP - Statewide Prevention Medial Relations           |  |   |                         |                   | х                      |                 |           |                        | x  | x                               |  |                           |   |
| WASAVP - Prevention Policy Speakers Bureau               |  |   |                         |                   | x                      |                 |           |                        | x  | x                               |  |                           | x                                       |
| WHY – Law Enforcement Partnerships                       | x  | x   |                         |                   | x                      | x               |           |                        |  | x                               |  | x                         | x                                       |
| WHY – Let's Draw the Line Between Youth and Alcohol      | x  | x   | x                       | x                 | x                      | x               | x         | x                      | x  | x                               |  | x                         | x                                       |
| WHY – Media Awareness Presentations with Miss Washington | x  | x   | x                       | х                 | х                      |                 |           |                        | x  | x                               |  |                           | x                                       |
| L  |  |   |                         |                   |                        |                 |           |                        |  |                                 |  |                           |   |

Page **115** of **130** 

| Resources by Strategy                                     | Youth Education/Skill<br>building - School based | Youth Education/Skill<br>building - Community | Parent education/family | Other Educational | Policy/community norms | Law enforcement | Mentoring | Alternative Activities | Community engagement/<br>coalition development | Youth leadership<br>development | Problem Identification and<br>Referral | Information Dissemination | Cross-system planning/<br>collaboration |
|---|--|---|-------------------------|-------------------|------------------------|-----------------|-----------|------------------------|--|---------------------------------|--|---------------------------|---|
| WHY - Analyze And Monitor Issues/Policies                 |  |   |                         |                   | x                      |                 |           |                        | x  | х                               |  |                           | x                                       |
| WHY - Promote Policy Change                               |  |   | x                       |                   | x                      |                 |           |                        | x  | x                               |  | x                         | x                                       |
| WHY - Supporting Youth Influencers                        |  | x   |                         |                   | x                      |                 |           |                        | x  | x                               |  | x                         | x                                       |
| WHY - Support Law Enforcement                             |  |   |                         |                   | x                      | x               |           |                        | x  | x                               |  |                           | x                                       |
| WSP - Master Management Of BAC Program                    |  |   |                         |                   |                        | x               |           |                        |  |                                 |  |                           |   |
| WSP - Limited Community Outreach                          | x  |   |                         |                   |                        |                 |           |                        |  |                                 |  |                           |   |
| WSP - Ignition Inner-Lock Program                         |  |   |                         | x                 |                        | x               |           |                        |  |                                 | x                                      |                           |   |
| WSP - Target Zero Teams                                   |  |   |                         | x                 | x                      | x               |           |                        |  |                                 |  | x                         | x                                       |
| WSU - Interdisciplinary PhD Program In Prevention Science |  | x   | x                       | x                 | x                      |                 |           |                        | x  | x                               |  |                           |   |
| WTSC - Click It or Ticket                                 |  |   |                         |                   | x                      | x               |           |                        |  |                                 |  |                           |   |
| WTSC - HS Distracted Driver Projects                      |  |   |                         |                   |                        | x               |           |                        |  | x                               |  |                           |   |
| WTSC - DUI Enforcement Campaigns                          |  |   |                         |                   | x                      | x               |           |                        |  |                                 |  |                           |   |
| WTSC - Traffic Safety Task Forces - Target Zero           |  |   |                         |                   |                        | x               |           |                        |  |                                 |  |                           | x                                       |
|   |  |   |                         |                   |                        |                 |           |                        |  |                                 |  |                           |   |

## 8. Learning Community Steering Committees

The table below summarizes the specific partners committed to contributing to working on each Learning Community Steering Committee.

The SPE Prevention Consortium no longer has learning or steering committees for SPE. SPE members participate on one of five (5) SPE workgroups. A list of workgroups is below.

- Underage Drinking & Youth Marijuana Misuse/Abuse Prevention Team Washington Healthy Youth (WHY) Coalition
- Prescription Drug Misuse/Abuse Prevention Team
- Tobacco Misuse/Abuse Prevention Team
- Young Adults & Pregnant Women Alcohol & Marijuana Misuse/Abuse Prevention Workgroup
- Mental Health Promotion Team

| Partner Agency/Organization (2015)   | Alcohol | Underage<br>Drinking &<br>Marijuana | Tobacco | Prescription<br>Drugs | Mental<br>Health |
|--|---------|-------------------------------------|---------|-----------------------|------------------|
| College Coalition for Substance Abuse Prevention (CCSAP)                       | Х       | Х                                   |         |                       |                  |
| Department of Early Learning (DEL)   |         |                                     |         |                       | Х                |
| Department of Health (DOH)   | Х       | Х                                   | Х       | Х                     | Х                |
| Division of Behavioral Health & Recovery (DBHR)                                | Х       | Х                                   | Х       | Х                     | Х                |
| Health Care Authority (HCA)  |         |                                     |         | Х                     | Х                |
| Liquor Control Board (LCB)   | Х       | Х                                   |         |                       |                  |
| Office of Indian Policy (OIP)  |         |                                     |         |                       | Х                |
| Office of Superintendent of Public Instruction (OSPI)                          |         | Х                                   |         |                       | Х                |
| Office of the Attorney General (AGO)   |         | Х                                   | Х       |                       |                  |
| Prevention Specialist Certification Board of Washington<br>(PSCBW)             | Х       | Х                                   |         |                       |                  |
| State Board of Health (SBOH)   |         |                                     | Х       | Х                     |                  |
| State Epidemiological Outcome Workgroup (SEOW)                                 | Х       | Х                                   | Х       | Х                     | Х                |
| Washington Association for Substance Abuse and Violence<br>Prevention (WASAVP) | х       | Х                                   | Х       |                       |                  |
| Washington Healthy Youth Coalition (WHY)                                       | Х       | Х                                   |         |                       |                  |
| Washington State Commission on Asian Pacific American<br>Affairs (CAPAA)       | Х       |                                     |         |                       | Х                |
| Washington State Drug Free Communities Coalition of<br>Coalitions (CoC)        | Х       | Х                                   | Х       | Х                     |                  |
| Washington State Patrol (WSP)  | Х       | Х                                   |         |                       |                  |
| Washington State Prevention Research Sub-Committee                             | Х       | х                                   | Х       | Х                     | Х                |
| Washington Traffic Safety Commission (WTSC)                                    | Х       | Х                                   |         |                       |                  |

#### Updated 2015 9. **Logic Model Evaluation Plan** outcomes (red, purple, PRAMS; LCB; CHARS) Using strategy specific Agency service data neasure our impact.. (see appendix for list of listed for each of the Using State Data So what? How will we know? ..and we will track CORE GIS (WTSC; Provider service Items related to process data: strategies - TBD the key indicators blue columns) to Sources: collaborative acronyms) · NSDUH BRFSS data ΗYS SPE Policy Consortium State Plan Logic Model Policy review, advocacy and promotion focused development related to SPE Consortium awareness campaigns **Collaborative** focused on problem Policy/Community problem areas and on problem areas doing about it education, and/or What are we Strategies collaboratively on dissemination: Public media, together? these strategies... Professional Information Education: strategies norms: ...and working areas Action (from resources assessment results) SPE Consortium planning/collaboration: Problem identification engagement/Coalition thru these strategies. Policy/Community doing about it? ...can be addressed 11 Agency/Orgs. Strategies What are we 11 Agency/Orgs 11 Agency/Orgs 9 Agency/Orgs development: dissemination: 9 Agency/Orgs 5 Agency/Orgs Cross-systems Partners' 24 resources 26 resources 65 resources 20 resources 20 resources and referral: 14 resources Information Education: Community norms: →Factors) (2-5 years) ← Perception of harm grade; young adult use (Where get substance (easy to get- HYS 10<sup>th</sup> harassment – HYS 10<sup>th</sup> (get caught-HYS 10<sup>th</sup> Community norms (school policies –HYS) **Risk/Protective** (risk of use–HVS 10<sup>th</sup> Intervening Why here? ...specifically with Variables (Child – TBD; Adult Enforcement HYS 10<sup>th</sup> grade) these common ACEs - BRFSS) (laws/norms; Experiences Availability Traumatic 10<sup>th</sup> grade) (HNDSN -Policies Access factors... grade) grade) grade) from data assessment results) **Problem Areas** (30-day use – HYS 10<sup>t</sup>) (30-day use – HYS 10<sup>th</sup> (use during pregnanc) Underage drinking (Sad/Hopeless in past use – HYS 10<sup>th</sup> grade) (30-day use-HYS 10<sup>th</sup> (30-day use; problem Prescription drug Suicide Ideation Tobacco misuse (5-10 years) 12 months – HYS) (suicide ideation – Outcomes Adult - Alcohol problem areas... misuse/abuse misuse/abuse misuse/abuse Why? These types of Depression Marijuana -BRFSS) /abuse grade) grade) grade) H<sub>VS</sub>) Graduation – CORE GIS (# of suicides/attempts Consequences (Alcohol/Drug –related (HS On-time/Extended serious injury from Injuries ages 16-25ages 10-25 -CHARS) Long-Term (10-15 years) Outcome arrests ages 10-25-Chronic Disease (ATOD Attributable Low Graduation (# Alcohol-Related What is the vehicle crashes Traffic Fatalities/ These problems... problem? Deaths - CHARS) Fatalities and CORE/WTSC) CORE GIS) Suicide Crime rates

Page 118 of 130

## 10. Prevention Consortium Team Accomplishments 2013-2014

## Washington Healthy Youth Coalition (WHY Coalition) Underage Alcohol Use Prevention Team Accomplishments

## **WHY Coalition**

- Leaders met with Attorney General Bob Ferguson to affirm continued commitment to underage drinking prevention.
- The new name for the coalition is Washington Healthy Youth coalition. The name change was necessary to reflect an emphasis on underage alcohol AND marijuana use.
- Coalition established a youth marijuana misuse/abuse prevention sub-group.
- Completed A3 Results Washington Planning Process.

## Let's Draw the Line between Youth and Alcohol

- Reaching 5,000 people in 42 communities.
- 2014 34 Washington community groups participated in the project this spring. Each community received up to \$1,000 for completion of a Community Assessment of Neighborhood Stores (CANS) surveys and their choice of two other projects from a menu of 10 possible projects. The project concluded June 30.

## Law Enforcement Partnerships

- Four communities participated in Spring 2013 with only 5% violation rate on sales to minors.
  - Communities were offered \$6,500 in funding to implement additional compliance, alcohol purchase surveys and community awareness work from spring break through graduation season.
    - Each coalition received training in working with law enforcement and media.
    - Law enforcement received training on Conducting Alcohol Compliance Checks.
  - There is funding for up to six communities to test new fidelity of implementation guidance for alcohol compliance checks and purchase surveys.
  - Seven Community Prevention and Wellness Initiative (CPWI) coalitions and one former Enforcing Underage Drinking Law (EUDL) Discretionary Grant recipient received up to \$3,000 to implement a combination of alcohol compliance checks, alcohol purchase surveys and community awareness about law enforcement. Many of the participating coalitions enjoyed being involved in implementing alcohol purchase surveys and reinforcing communication to stores and staff who asked for identification.
    - The eight coalitions are: Oak Harbor (Island County), Concrete (Skagit County), Castle Rock (Cowlitz County), West Central Spokane (Spokane County), Moses Lake (Grant County), Quincy (Grant County) and Omak (Okanogan County).
  - A no-cost extension has been submitted to the office of Juvenile Justice Delinquency Prevention for EUDL Block Grant and a budget revision of the EUDL Discretionally Grant.

### I-1183 Advisory Committee

• Linda Becker, Ph.D., DBHR and Julia Dilley, Ph.D., Multnomah County, OR, presented preliminary findings regarding increases in use by youth and changes in attitudes toward use by youth in our state.

## Young Adults & Pregnant Women Alcohol & Marijuana Misuse/Abuse Action Team Accomplishments

- Developed an action plan to provided outreach to colleges and universities and used training funds from Screening, Brief Intervention, and Referral to Treatment (SBIRT) grant to support non-grantee sites with training.
- Coordinating conference in October 2014 to provide SBIRT Training to healthcare community.
- Department of Health (DOH) is now creating online training for physicians, nurses and other healthcare workers through the WHIN institute.

## Marijuana Misuse/Abuse Prevention Action Team Accomplishments

## **Engage Liquor Control Board in Rule Making**

 LCB provided recommendations to legislature on Medical Marijuana (MMJ) and included several protective factors to support and several risk factors MMJ to youth and 18-21 year old segments (home grows allowed, tax breaks, and increased purchase amounts). The team continues to educate rule makers about these issues and to also communicate to prevention field (Washington Association of Substance Abuse and Violence (WASAVP) and Coalition of Coalitions (CoC)).

### Website and Resources & FAQ's

- FAQ's completed. Info now available statewide at <u>www.learnaboutmarijuanawa.com</u>.
- Built page on Athena for Marijuana Misuse/Abuse Prevention http://www.theathenaforum.org/marijuana.
- Marijuana Education Movie completed and available online and in hard copy—dissemination taking place with CPWI, DFC, and WASAVP— exploring dissemination via Office of Superintendent of Public Instruction (OSPI). Consider updating movie for 2014.
- Map created of Marijuana Stakeholders and state agency roles to help guide workgroup mission and analyze gaps.
- Parent Tool Kit collaboratively developed with DOH, LCB, DBHR and Inga Manskopf and Dr. Leslie Walker of Seattle Children's Hospital for parents of middle school youth. Inga Manskopf, Dr. Walker and Kevin Haggerty, Ph.D. and Rico Catalano, Ph.D. (UW-SDRG) developed original guide. Toolkit available on the Athena Forum <a href="http://www.theathenaforum.org/parenttoolkit">http://www.theathenaforum.org/parenttoolkit</a>.
- <u>Parent Guide to MJ</u> article in *Parent Map* agrees that parents should use zero tolerance messages with youth.

### **Conference to gather state leaders and key stakeholders**

• Youth Marijuana Use Prevention symposium, completed July 2013.

## **Tobacco Misuse/Abuse Prevention Team Accomplishments**

## Participated in and Presented at TAP Summit

- December 2013, Attended by 117 people.
  - Included a call for advocates to join efforts with Heart, Lung, & American Cancer Society.
  - Held a health meeting to address the creation of a community driven, statewide tobacco coalition that will provide advocacy prevention funding.

## Washington Health Improvement Network (WHIN)

• Webinar for healthcare providers on screening and referring patients to cessation services.

## The Fresh Air Campus Challenge

• November 2013, Great American Smoke Out day campuses: Tacoma Community College, University of Washington, Tacoma, Edmonds Community College and Walla Walla Community College promoted a one day smoke free policy.

## **Other Tobacco Abuse Prevention Accomplishments**

- Attorney General Ferguson, along with other state attorneys general will sign a letter to the FDA urging the FDA to ban menthol cigarettes.
- Staff from the Attorney General's office (AGO) sent a letter to R.J. Reynolds asking for information about recent magazine advertising campaigns, which raise concerns about youth exposure to cigarette advertising.
- Several public health organizations and six state attorneys general sent a letter to the CEO of Comcast (which owns Universal Studios) requesting that marketing materials for the upcoming feature film *Rush* be scrubbed of smoking and cigarette brand imagery.
- Meeting with Parent Teacher Association (PTA) Executive Director and provided information on movie smoking to help inform membership about the issue.
  - Resulted in a basis for making contact with the national PTA office.
  - Working with staff at Legacy to arrange a meeting between federal Health and Human Service officials and the national PTA Executive Director to discuss grass roots involvement in the movie smoking issue.
- Washington is chairing a recently-formed working group of state AGOs to review and update priorities for AGOs' public health-related work under the Master Settlement Agreement (MSA) (there are other MSA issues, such as enforcing payment requirements, dealing with bankrupt tobacco companies, etc., that do not directly involve advancing public health).
- Washington participated in a working group which submitted comments to the (FDA) on its proposed rule regarding the deeming of certain products to be "tobacco products."
- Washington continues to chair a workgroup on smoking in the movies, which is actively working with other stakeholders to develop policy advocacy and media strategies. The ultimate goal is to eliminate smoking in youth-rated movies (a goal that is also included in the SPE Strategic Plan).
- Washington continues to co-chair a working group that encourages and supports collaboration between state health departments and state AGOs.

- Washington State University adopted tobacco-free campus policy.
- Built Athena page for Tobacco Abuse Prevention <u>http://www.theathenaforum.org/tobacco</u>.

## Prescription Drug Misuse/Abuse Prevention Action Team Accomplishments

### **Information Dissemination to Communities**

- Built Athena page for Prescription Drug Abuse Prevention <u>http://www.theathenaforum.org/rx</u>.
- Reached out to Higher Education to promote this information (college coalition, and doctors in training).
- Conducted several presentations including;
  - State Board of Health @ SeaTac from King County Take Back Program November 2013.
  - Joint Conference on Health (annual) presentation/exhibit table for Take Back Your Meds– October 2013 to October 2015. <u>www.wspha.org.</u>
  - Board of Health presentation November 2013.
  - Prescription Statistics represented at Prescription Monitoring Program (PMP) National Meeting.
  - June 2014 group presentation to College Coalition available online.
  - Provided 10,000 Good Samaritan Law / 911 Overdose Prevention Cards to 52
     Washington State community coalitions for local distribution.

## Promote Value of Prescription Monitoring Program (PMP) to get continued advocacy

- PMP article sent to HCA.
- HB 1565 passed Funding for Prescription Drug Monitoring.
  - In budget little over \$500,000/year for 2.0 FTE; Vendor system costs (~200,000/year) and Education/outreach.
- Drug take-back law passed by King County Board of Health.
- Received funding as part of PFS grant to incorporate PMP data into our data books for local communities.

## **Mental Health Promotion Action Team Accomplishments**

- Suicide prevention training to coalitions in Battleground, North Kitsap, Gig Harbor, King County, Bellingham, Forks, Spokane, Wenatchee, and Grays Harbor. Information, strengths and challenges collected.
- Statewide Suicide Prevention Day launched on September 2013 with Governor's Proclamation. Multiple agencies held activities statewide.
- Collaboration with DOH on training health care professionals in suicide prevention, youth suicide prevention activity.
- NW Indian College partnered with Colville Confederated Tribes last year on Suicide Prevention project.
- University of Washington (UW) has Substance Abuse and Mental Health Services Administration (SAMHSA) funded suicide prevention project for students at Seattle campus.
- Met with DSHS Secretary Quigley re: suicide prevention with Native American focus.

- Group created a website page on the Athena Website: <u>http://theathenaforum.org/mentalhealth</u>.
- Training Educational Service Districts (ESD) how to use plan. Material should be up on the OSPI school safety website.
- Forefront has training curricula for nurses' schools and others in suicide prevention.
- DOH submitted 2014 suicide prevention SAMHSA grant, put together by MH Promotion Team Committee members.
- Juvenile Justice and Rehabilitation Administration (JJRA) and Suicide Prevention Conference September 2014 at Great Wolf Lodge.
- Department of Health (DOH) will be convening a steering committee to develop a statewide plan for suicide prevention across the lifespan August 2014.
- Promoted establishment of permanent cross agency statewide suicide prevention and mental health promotion group.
- Supported *Mental Health First Aid Training* implementation in collaboration with OSPI.
- Supported Department of Health (DOH)/Division of Behavioral Health and Recovery's (DBHR) effort to expand Washington's data on suicide and violent death reporting statistics.

## 11. Prevention Consortium Team Accomplishments 2014-2015

## Washington Healthy Youth Coalition (WHY Coalition) Underage Drinking and Marijuana Team Accomplishments

## Let's Draw the Line between Youth and Alcohol

 The Let's Draw the Line mini-grants applications were released February 2015 38 groups completed the 2015 LDTL. The groups were awarded \$1,000 for their completion of Community Assessment of Neighborhood Stores (CANS) surveys, implementation of one of the Above the Influence projects, and their choice of another projects from a menu 6 possible projects.

## Law Enforcement Partnership

- Three communities participated in the Law Enforcement Partnership mini-grants. Communities included Tenino/Bucoda, Castle Rock, Klickitat-Lyle
  - Awarded communities implemented a mix of underage drinking prevention strategies, with a major focus on working with their local and county law enforcement agencies and local media. The communities conducted alcohol purchase surveys, compliance checks, and a media awareness plan.

## **Policy Impact Team**

- Clarified process for reporting violations and it was determined that violations should be reported to Liquor Control Board (LCB). LCB's role is primary enforcer of marijuana law and rules.
- Literature Review is available for stakeholders to utilize to advocate for the regulation and inherent dangers of certain edibles.
  - Policy paper is available for utilization and provided to LCB for reference.
- LCB enacted emergency rules to address MJ edibles.
- Stakeholders and policy makers become better informed about powdered alcohol and its potential implications for underage drinking. The paper was read and/or discussed by agency officials, stakeholders and legislators.
  - House Bill 5292 was passed and signed by the governor. The bill prohibits the possession, use and sale of powered alcohol.
- Expansion of RVP to beer/wine retailers approved by the LCB. Beer/wine retailers are joining RVP, 15 coalitions are working with LCB to promote the RVP to order to increase compliance rates for no sales to minors.

### **Communications Impact Team**

- Completed talking points for communities: June 2014. Info card for parents translated into 8 languages. Distributed online and by WA Commission on Asian Pacific American Affairs.
  - DBHR funded an updated translation of the Cambodian card, and a new translation in Mien. They are now uploaded to the UW site. The plan is to print copies of the Asian language cards and make them available for ordering through the DES webpage for publications. When this is set up, will post on Athena.
  - Communications staff updated the Marijuana Prevention Toolkit page on Athena with links to all of the translated cards.
- Printed 50,000 parent guides and fact cards <u>Toolkit is online</u> and Distributed to Schools through ESDs.
- DOH launched one-month radio and online marijuana educational campaign targeting parents. Announced by Governor Inslee on June 2014 with 34.8 million impressions. 38,888 visits to campaign website.
- Dr. Walker radio ad airing statewide beginning May 2015 to educate the State's parents about State's law regarding recreational marijuana use (I-502).
  - Parents will be directed to StartTalkingNow website for more information, and tips on talking with their kids about the risks of marijuana.
- In March, fact sheets and talking points were updated with the 2014 Healthy Youth Survey results. Updated tools are being added online regularly.
- A new video for parents with prevention tips from a pediatrician was posted to the Starttaklingnow.org webpage on January 2015.
- The Start Talking Now (STN) homepage is currently under redesign. New pages are being created for parents in multiple languages. Spanish language page for parents was completed June 2015.
- Interview with Bea Mendez with Univision, Spanish language station.

## Young Adults & Pregnant Women Alcohol & Marijuana Misuse/Abuse Action Team Accomplishments

- Hosted a 1-day SBIRT training/conference to teach medical provides about SBIRT services. Provided a platform for Dr. Jason Kilmer, Dr. Paul Grossberg and Dr. Jim Schaus.
- Disseminated the *Substance Abuse During Pregnancy: Guidelines for Screening and Management* best practice guide, via email and list serves.
  - o <a href="http://here.doh.wa.gov/materials/guidelines-substance-abuse-pregnancy">http://here.doh.wa.gov/materials/guidelines-substance-abuse-pregnancy</a>
- Completed WSHA Safe Deliveries Roadmap standards/QI project. Purpose of standards is to improve care and insure comprehensive care including screening and referring for substance use/abuse. Standards finalized and vetted with all the sub advisory committees who developed

them; released spring 2015. Project included recommended evidence-based standards for primary care for child-bearing age and pregnancy care. SBIRT is included in these standards.

- Women's Healthy messages portal page and factsheet on the DOH webpage.
- DOH webpage health information for pregnant women.
  - o <a href="http://www.doh.wa.gov/YouandYourFamily/WomensHealth">http://www.doh.wa.gov/YouandYourFamily/WomensHealth</a>
  - o <a href="http://www.doh.wa.gov/YouandYourFamily/WomensHealth/Pregnancy">http://www.doh.wa.gov/YouandYourFamily/WomensHealth/Pregnancy</a>
- College Coalition for Substance Abuse Prevention hosted a year end conference.

## Prescription Drug Prevention Action Team Accomplishments

## **Information Dissemination to Communities**

- Jennifer Sable presented the background (history and purpose) of the UPWG and PMP. Also
  presented on Opioid Guidelines revision. Some of the major changes/updates we can expect to
  see in the release of these new guidelines are centered on the procedures and guidelines for
  Emergency Room Departments.
- ER departments and Safeway pharmacies are using the DOH "Take as Directed" brochures. The update released on June 2015.
- Alex Schwartz presented to the Pain Medicine Department at Harborview medical Center on March 2015 and educated the physicians and health care team on the PMP.
- Presented to providers at Co-Occurring Conference and to the College Coalition

## Promote Value of Prescription Monitoring Program (PMP) to get continued advocacy

- Analyzed new DEA regulation on take-back of controlled substances.
- Outreach provided to stakeholders, including pharmacies, law enforcement, and local governments on impacts to existing medicine take-back programs and establishment of any new take-backs.
- Promoted DEA Take-Back event Sept. 2014 to CPWI sites during monthly meeting and on The Athena Forum.
- Distributed a total of 10,000, "911/Good Samaritan Law Cards" to 52 CPWI coalitions for local distribution.
- Developed messaging to share with prescribers to encourage use of PMP.
- Supported announcement distribution of Opioid Summits to constituents.
- Successfully supported five (5) Community Prevention and Wellness Initiative Communities in Prescription Drug Take Back Projects.
- Completed comparison of toxicology results from King County to codes on death certificate.
- Met with King County Medical Examiner (ME) to discuss results and ideas to reaching out to other MEs and coroners.
- Met with state toxicologist to request toxicology data on drug overdose cases.
  - Scheduled to receive regular data to analyze.

## **Mental Health Promotion Action Team Accomplishments**

## HB 2315 Implementation

• Completed Statewide Suicide Prevention plan with statewide partners. Plan is currently under review.

## **Tobacco Abuse Prevention Team Accomplishments**

- Landlord survey implemented to determine the percentage of apartments with a no-smoking policy. Results were available spring 2015.
- Kick Butts Day included outreach to college campuses.
- 3 relevant bill considered by legislature with significant impact including raising smoking age to 21, raising fines and fees for tobacco and regulating e-cigarettes, and allowing cigar bars as an exception to smoking in public places.
- CANS results for 2014 tabulated and distributed to partners.
- We are continuing to promote cessation and especially promoting our smart phone cessation app that we encourage everyone to add to their web site and promote any other way possible.
  - DOH pays for the fee to use the full version of the app for anyone living in Washington State. Get details at <u>www.quitline.com</u>
- WHIN program has experience almost complete turn-over in staff and now has a new section manager with pans to re-staff program.
- Smoking in Movies: On June 29 Disney adopted a broadened tobacco policy, extending to its Lucasfilm, Marvel and Pixar labels its policy that was previously applied only to Disney-branded films. Individual studio policies are a less-effective means than a change in the movie rating system for protecting kids against tobacco impressions in youth-rated movies, because they contain loopholes and are not consistently enforced (one outstanding question regarding Disney's policy is whether it will apply to Touchstone films, which in the past have been a pipeline for smoking in youth-rated movies). Nevertheless, given the dose-response relationship between tobacco exposures from movies and youth smoking initiation, Disney's move may result in some amount of reduced youth-smoking initiation.
- Age 21/e-cigarettes: Although neither bill was enacted, we began to build support in the legislature and elsewhere for major policy changes.
- \*Youth smoking rate: Continued decline, as reported in the HYS results.

## 12. Significant Events Influencing the Field of Prevention from 2010-2015

| Significant Events in WA   | Year      | Economic | Policy/ Law | Change in |
|--|-----------|----------|-------------|-----------|
| 2010-2015  |           | Event    | Change      | Funding   |
| Passing of the Good Samaritan Laws /<br>SB 1671 - Opioid overdose prevention                               | 2010/2015 |          | Х           |           |
| Tobacco sales tax structure changes  | 2010      | Х        | Х           |           |
| Passage of Initiative 1183 Liquor privatization  | 2011      |          |             |           |
| Strengthened managed care monitoring   | 2011      |          | Х           |           |
| Contract Language re: Mental Health Services   | 2012      |          | Х           |           |
| Elimination of Family Policy Council funding   | 2012      |          |             | Х         |
| Passing of I-502 Non-medical Marijuana<br>Legalization   | 2012      |          | Х           |           |
| Elimination of Community Mobilization<br>funding   | 2013      |          |             | Х         |
| SIM Grant Awarded to Health Care Authority<br>& Accountable Communities of Health                          | 2013      |          |             | Х         |
| Vast expansion of electronic cigarette<br>industry/marketplace   | ~ 2013    |          | Х           |           |
| Added SBIRT to Medical Benefit   | 2014      |          | Х           |           |
| Garret Lee Smith Grant awarded DOH   | 2014      |          |             | Х         |
| House Bill 2315 passed (suicide prevention)  | 2014      |          | Х           |           |
| WA Prescription Drug Monitoring Program<br>(PMP) State funded  | 2014      |          | Х           | Х         |
| Significant decrease in youth perception of<br>harm (marijuana use)  | 2014      |          |             |           |
| DEA Rules on Rx Drugs and Drug Take-back<br>Program ended  | 2015      |          | Х           |           |
| Youth Mental Health First Aid Pilot Efforts  | 2015      |          |             | Х         |
| Oregon/ Alaska retail marijuana legalization   | 2015      |          | Х           |           |
| Potential developmental Screening for young children   | 2015      |          | Х           |           |
| Expansion of home visiting (2 million)   | 2015      |          |             | Х         |
| SB 5052 passed: legalized medical marijuana/<br>home grows   | 2015      | Х        | Х           |           |
| Strengthened language in contract re: Early<br>and Periodic Screening, Diagnostic and<br>Treatment (EPSDT) | 2015      |          | Х           |           |
| Tax funding from I-502 for prevention and treatment programs allocated                                     | 2015      |          | Х           | Х         |
| Tribes able sell and produce marijuana legally   | 2015      | Х        | Х           |           |
| DBHR requires CPP credential for community coalition coordinators.   | 2015      |          | Х           |           |
| Health Care Reform - Behavioral Health<br>Organizations (BHO)  | 2015/2016 |          | Х           |           |

This report was originally prepared in 2011, and updated in 2013 on behalf of all of the partners of the State Prevention Enhancement Policy Consortium by Sarah Mariani, State Prevention Enhancement Project Manager, DBHR, with support from Chris Imhoff, Director, DBHR; and guidance from Michael Langer, Behavioral Health Administrator, DBHR; Sue Grinnell, Division of Prevention and Community Wellness Director, Department of Health; and Rusty Fallis, Assistant Attorney General, Office of the Attorney General.

2015 update prepared on behalf of all of the partners of the State Prevention Enhancement Policy Consortium by Julia Havens, Prevention System Development Manager and Lucilla Mendoza, Prevention System Manager, DBHR, with support from Chris Imhoff, Director, DBHR, and guidance from Sarah Mariani, Behavioral Health Administrator, DBHR; David Hudson, Section Manager, Community-Based Prevention Office of Healthy Communities Department of Health; and Robert (Rusty) J. Fallis, Assistant Attorney General, Office of the Attorney General.

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*For more information about the State Prevention Enhancement projects and planning, go to* <u>www.TheAthenaForum.org/SPE</u>.

# **State Prevention Enhancement Policy Consortium Partners**



COLLEGE COALITION FOR







Washington State Department of Early Learning

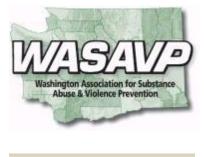




Washington State Liquor and Cannabis Board

Washington State Health Care Authority









Prescription Review

Prescribe health Dispense safely





Page 130 of 130

## Environmental Factors and Plan

#### 10. Statutory Criterion for MHBG - Required MHBG

#### Narrative Question

#### Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

#### Please respond to the following items

#### **Criterion 1**

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occuring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

The Behavioral Health Organizations contract for a wide variety of services in support of the individuals in their catchment area to live in their communities. At the lower service level there is brief intervention. Some examples of the services provided on a community level include outpatient mental health counseling, group and family treatment, case management, medication management, and medication monitoring. There are also higher level of outpatient resources such as crisis services, services for youth and families, respite services, and the program of assertive community treatment (PACT). Additional services to support individuals in the community include care coordination, engagement and outreach services, housing and recovery through peer services, mental health club houses, as well as supported employment.

2. Does your state provide the following services under comprehensive community-based mental health service systems?

| a) | Physical Health  | jn Yes jn No |
|----|--|--------------|
| b) | Mental Health  | jn Yes jn No |
| C) | Rehabilitation services  | ja Yes ja No |
| d) | Employment services  | ja Yes ja No |
| e) | Housing services   | ja Yes ja No |
| f) | Educational Services   | ja Yes ja No |
| g) | Substance misuse prevention and SUD treatment services   | ja Yes ja No |
| h) | Medical and dental services  | ja Yes ja No |
| i) | Support services   | ja Yes ja No |
| j) | Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA) | jn Yes jn No |
| k) | Services for persons with co-occuring M/SUDs   | jn Yes jn No |

Please describe as needed (for example, best practices, service needs, concerns, etc)

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

Washington State Case Management includes a range of activities provided by the outpatient community mental health agency's liaison in or with a facility for the direct benefit of an individual in the public mental health system. To be eligible, the individual must be in need of case management in order to ensure timely and appropriate treatment and care coordination. Activities include assessment for discharge or admission to community mental health care, integrated mental health treatment planning, resource identification and linkage to mental health rehabilitative services, and collaborative development of individualized services that promote continuity of mental health care. These specialized mental health coordination activities are intended to promote discharge, to maximize the benefits of the placement and to minimize the risk of unplanned readmission, and to increase the community tenure of the individual.

4. Describe activities intended to reduce hospitalizations and hospital stays.

Ensuring the right amount of care is available at the right time is key to reducing the need for hospitalization. Washington State requires each Behavioral Health Care Organization (BHO) within a designated region to ensure that a specific array of core mental health services are offered within the BHO's network. These services span the continuum of care, ranging from less intensive outpatient services (i.e. therapeutic psychoeducation, brief intervention services, individual or group therapy), to more intensive multi-disciplinary team delivered services (i.e. Wraparound with Intensive Services, Program for Assertive Community Treatment), to more structured and stabilization focused care (i.e. mental health services in a residential setting, crisis stabilization services, evaluation and treatment in an inpatient setting). Peer support services are provided along the continuum of care, to promote a strength based and person centered approach. Crisis outreach services and crisis support lines are offered on a 24/7 basis, always with the intention of offering the least restrictive alternative options to hospitalization. Washington State requires each BHO to meet and maintain network adequacy, appointment, response, and distance standards to ensure individuals have sufficient and timely access to care.

Appropriately decreasing the length of hospital stays and readmission rates hinges upon continuous and thorough discharge planning, as well as access to appropriate step down options. Each BHO utilizes hospital liaisons within their region to assist with the discharge planning at the state hospitals, as well as at the evaluation and treatment facilities. Washington State recently provided additional funding to the BHOs to further support dedicated discharge planners at the evaluation and treatment centers. Additionally, the state launched a Peer Bridger Pilot program that integrates peer counselors into each BHO hospital liaison team to facilitate discharge planning and to support successful transition and continuity of care as individuals return to their communities.

Appropriate step down options are often hindered by a lack of safe and stable housing for individuals leaving a hospital setting. Washington has now entered into a five-year agreement with the Centers for Medicare and Medicaid Services (CMS) that provides federal funding for regional health system transformation projects. One of the three initiatives under this demonstration will focus on providing more supportive housing opportunities and services. It is anticipated that this increase in both funding and flexibility to help individuals with behavioral health needs obtain and maintain housing will bolster discharging efforts and enhance step down options.

#### Criterion 2: Mental Health System Data Epidemiology

Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

#### Criterion 2

In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus.

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state's behavioral health system

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

| Target Population (A) | Statewide prevalence (B) | Statewide incidence (C) |
|-----------------------|--------------------------|-------------------------|
| 1.Adults with SMI     | 297,248                  |                         |
| 2.Children with SED   | 63,879                   |                         |

Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

Data source: URS Table 1; prevalence estimate year 2015 SAMHSA

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

#### Criterion 3: Children's Services

Provides for a system of integrated services in order for children to receive care for their multiple needs. Services that should be integrated into a comprehensive system of care include: social services; educational services, including services provided under IDEA; juvenile justice services; substance abuse services; and health and mental health services.

### Criterion 3

Does your state integrate the following services into a comprehensive system of care?

| a) | Social Services  | jn Yes jn No |
|----|--|--------------|
| b) | Educational services, including services provided under IDE                      | jn Yes jn No |
| c) | Juvenile justice services  | ja Yes ja No |
| d) | Substance misuse preventiion and SUD treatment services                          | ja Yes ja No |
| e) | Health and mental health services  | ja Yes ja No |
| f) | Establishes defined geographic area for the provision of services of such system | jn Yes jn No |

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults

Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.

#### Criterion 4

Describe your state's targeted services to rural and homeless populations and to older adults

Washington State supports several programs throughout the state that provide targeted outreach to homeless individuals. Projects for Assistance in Transition from Homeless (PATH) provides persistent and consistent outreach to individuals experiencing homelessness to assist in accessing housing, behavioral health services, and other services to facilitate recovery and stabilization. Housing and Recovery through Peer Services (HARPS) is a team based approach, utilizing certified peer counselors and mental health professionals to provide community based services to at risk individuals. Priority populations for HARPS services include individuals who are homeless or at risk at becoming homeless, as well as individuals discharging from inpatient psychiatric settings.

Washington State requires each Behavioral Health Care Organization (BHO) within a designated region to maintain an adequate provider network that meets the specific regional needs. For rural areas, the BHO must ensure that the location of their providers are within reasonable maximum distance standards. In addition, the state imposes access requirements through contract which requires the BHOs to provide community based intake assessments at an individual's home or living facility, such as assisted living, adult family home, or skilled nursing facility.

In regards to serving the older adult population, the BHOs must provide or purchase age appropriate and culturally competent community behavioral health services for their enrollees whom services are medically necessary and clinically appropriate. BHOs are required to analyze demographic data (including age) at least annually, to determine if their network is adequately serving the population of that region and to inform ongoing quality improvement. Providers within the BHO networks are required to provide onsite intake assessments and services at assisted living facilities, skilled nursing facilities, and adult family homes when requested by either the individual or the facility. Washington State ensures that Preadmission Screening and Resident Review (PASRR) are conducted statewide to ensure that individuals with mental health needs referred to skilled nursing facilities are not inappropriately placed in nursing homes.

#### Criterion 5: Management Systems

States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

#### Criterion 5

Describe your state's management systems.

DBHR uses MHBG funds to purchase and provide training to community mental health providers across the state. Examples of training include: training in PACT fidelity and technical assistance and those EBPs included in the PACT model (CBT, Supported Employment, Supportive Housing), Supportive Housing, Supported Employment, and Cognitive Behavioral Therapy for Psychosis. DBHR also purchases training for increasing the workforce of Certified Peer Counselors and provides training for Designated Mental Health Professionals who are responsible for providing on-site emergency evaluations of individuals who may need voluntary or involuntary treatment. After April 1, 2018, these individuals will also be responsible for responding to emergencies with either mental health issues or issues revolving around substance use disorders. We are currently training the entire statewide work force in conducting SUD evaluations and co-occurring evaluations for voluntary and involuntary treatment.

#### Footnotes:

Wraparound with Intensive Services (WISe), a service delivery model, provides children and youth service coordination to receive care for their multiple needs. WISe is designed to provide comprehensive behavioral health services and supports to Medicaid eligible individuals, up to 21 years of age with complex behavioral health needs. Youth with complex needs are usually involved in more than one child serving system such as child welfare, juvenile justice, social services and education. WISe requires referral and coordination with various services and systems. WISe also requires a single Cross System Care Plan based the child/youth individual needs and the other child serving systems involved in their lives. WISe is currently phasing in across the state and will be available in all counties by June 2018.

## Environmental Factors and Plan

11. Substance Use Disorder Treatment - Required SABG

### Narrative Question

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

### Criterion 1

b)

### Improving access to treatment services

- 1. Does your state provide:
  - a) A full continuum of services

| i)  | Screening                      |                                     | jn Yes jn No |  |  |
|---|--------------------------------|-------------------------------------|--------------|--|--|
| ii)                                       | Education                      |                                     | ja Yes ja No |  |  |
| iii)                                      | Brief Intervention             |                                     | ja Yes ja No |  |  |
| iv)                                       | Asses                          | sment                               | ja Yes ja No |  |  |
| v)  | Detox (inpatient/social)       |                                     | ja Yes ja No |  |  |
| vi)                                       | Outpatient                     |                                     | ja Yes ja No |  |  |
| vii)                                      | Intensive Outpatient           |                                     | ja Yes ja No |  |  |
| viii)                                     | Inpatient/Residential          |                                     | ja Yes ja No |  |  |
| ix)                                       | Aftercare; Recovery support    |                                     | jn Yes jn No |  |  |
| Are you considering any of the following: |                                |                                     |              |  |  |
|   | Targeted services for veterans |                                     | ja Yes ja No |  |  |
|   | Expansion of services for:     |                                     |              |  |  |
|   | (1)                            | Adolescents                         | ja Yes ja No |  |  |
|   | (2)                            | Other Adults                        | ja Yes ja No |  |  |
|   | (3)                            | Medication-Assisted Treatment (MAT) | jn Yes in No |  |  |

#### Narratve Question

Criterion 2: Improving Access and Addressing Primary Prevention - See Narrative 9. Primary Prevention-Required SABG.

### Criterion 2

#### Criterion 3

| 1. | Does your state meet the performance requirement to establish and/or maintain new programs or expand programs to ensure treatment availability?                                   |  |                |  |
|----|---|--|----------------|--|
| 2. | Either directly or through and arrangement with public or private non-profit entities make pernatal care available to PWWDC receiving services?                                   |  |                |  |
| 3. | Have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care? |  |                |  |
| 4. | Does your state have an arrangement for ensuring the provision of required supportive services?   |  |                |  |
| 5  | Are yo  | Are you considering any of the following:  |                |  |
|    | a)  | Open assessment and intake scheduling  | ja Yes ja No   |  |
|    | b)  | Establishment of an electronic system to identify available treatment slots      | ja Yes ja No   |  |
|    | c)  | Expanded community network for supportive services and healthcare                | ja Yes ja No   |  |
|    | d)  | Inclusion of recovery support services   | ja Yes ja No   |  |
|    | e)  | Health navigators to assist clients with community linkages                      | ja Yes ja No   |  |
|    | f)  | Expanded capability for family services, relationship restoration, custody issue | jn Yes in No   |  |
|    | g)  | Providing employment assistance  | jn Yes in No   |  |
|    | h)  | Providing transportation to and from services                                    | jn Yes in No   |  |
|    | i)  | Educational assistance   | jin Yes jin No |  |

6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

Strategies for prioritizing pregnant women are contained within the contract language between the state of Washington, the Behavioral Health Organizations (BHOs), and the Fully Integrated Managed Care (FIMC) regions. The BHOs and FIMC must publicize the availability of treatment services to PPW clients at the facilities, as well as the fact that PPW clients receive priority admission.

The BHOs and FIMC work with agencies to get pregnant women into services within 24 hours, if a residential placement is not available interim services are provided. If residential treatment is not needed, the individual is enrolled in outpatient treatment. When services are not available, the provider is required to ensure the following:

- Provision of, referral to, or counseling on the effects of alcohol and drug use on the fetus.
- Referral to prenatal care.
- Provision of, or referral to, human immunodeficiency (HIV) and tuberculosis (TB) education.
- Referral for HIV or TB treatment services if necessary.
- PPW receiving treatment are treated as a family unit.

The following services are provided directly or arrangements are made for the provision of the following services with sufficient case management and transportation to ensure women and their children have access to services provided below:

- Primary medical care for women, including referral for prenatal care and childcare while the women are receiving such services.

- Primary pediatric care including immunization for their children.

- Gender specific SUD treatment and other therapeutic interventions for women which may address issues of relationships, sexual and physical abuse, and parenting are provided.

- Provide, directly or through arrangements with other public or nonprofit private entities, childcare to individuals participating in assessment and treatment activities, and supportive activities such as support groups, parenting education, and other supportive activities when those activities are recommended as part of the recovery process noted in the individual's treatment plan.

- Therapeutic interventions for children in custody of women in treatment which may, among other things, address their developmental needs, their issues of sexual abuse and neglect.

- Substance Use Disorder Assessment Services specific to PPW.

- Services specific to Post-Partum Women.

- Services may continue to be provided for up to one year postpartum.

The BHOs and FIMC must ensure assessment requirements in addition to standard assessment service, to include a review of the gestational age of fetus, mother's age, living arrangements, and family support data.

A pregnant woman who is unable to access residential treatment due to lack of capacity and is in need of detoxification, can be referred to a Chemical Using Pregnant (CUP) program for admission, typically within 24 hours.

### Narratve Question

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

## Criterion 4,5&6

2.

## Persons Who Inject Drugs (PWID)

1. Does your state fulfill the:

| a)    | 90 percent capacity reporting requirement  | jn Yes jn No |
|-------|--|--------------|
| b)    | 14-120 day performance requirement with provision of interim services                              | jn Yes jn No |
| c)    | Outreach activities  | jn Yes jn No |
| d)    | Syringe services programs  | jn Yes jn No |
| e)    | Monitoring requirements as outlined in the authorizing statute and implementing regulation         | jn Yes jn No |
| Are y | ou considering any of the following:   |              |
| a)    | Electronic system with alert when 90 percent capacity is reached                                   | jn Yes jn No |
| b)    | Automatic reminder system associated with 14-120 day performance requirement                       | ja Yes ja No |
| c)    | Use of peer recovery supports to maintain contact and support                                      | jn Yes jn No |
| d)    | Service expansion to specific populations (military families, veterans, adolescents, older adults) | jn Yes jn No |

3. States are required to monitor program compliance related to activites and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

Strategies for prioritizing persons who inject drugs (PWID) is contained within the contract language between the state of Washington, the Behavioral Health Organizations (BHO), and the Fully Integrated Managed Care (FIMC) Organizations. The BHOs and FIMC must publicize the availability of treatment services to PWID at the facilities, as well as the fact that PWID receive priority admission. In addition, the BHOs and the FMIC must ensure that outreach is provided to priority populations. The outreach activities must be specifically designed to reduce transmission of HIV and encourage PWID to undergo treatment.

If treatment services are not immediately available interim services are made available until an individual is admitted to a substance abuse treatment program. The purpose of the service is to reduce the adverse health effects of such abuse, promote the health of the individual, and reduce the risk of transmission of the disease.

The BHOs and FIMC are required to submit a yearly project plan on how the services and the requirements in the contract will be adhered to. The project plans are reviewed and approved by DBHR. The BHOs and FIMC are required to submit annual progress reports that include what outreach models were used to PWID to enter treatment.

## Tuberculosis (TB)

| 1. | Does your state currently maintain an agreement, either directly or through arrangements with other        | in Yes in No |
|----|--|--------------|
|    | public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD | j i j i      |
|    | treatment and to monitor the service delivery?   |              |
| 2  | Are you considering only of the following:   |              |

2. Are you considering any of the following:

| a) | Business agreement/MOU with primary healthcare providers                      | ja Yes ja No |
|----|---|--------------|
| b) | Cooperative agreement/MOU with public health entity for testing and treatment | jn Yes jn No |
| c) | Established co-located SUD professionals within FQHCs                         | jn Yes jn No |

3. States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

The BHOs and the FIMC must directly or through arrangement with other public entities, make tuberculosis services available to individuals receiving SUD treatment. The services must include tuberculosis counseling, testing, and providing for or referring individuals infected with tuberculosis for appropriate medical evaluation and treatment.

In the case an individual in need of treatment services is denied admission to the tuberculosis program on the basis of the lack of capacity, the BHO will refer the individual to another provider of tuberculosis services. The BHOs and FIMC must conduct case Printed: 8/30/2017 4:04 PM - Washington - OMB No. 0930-0168 Approved: 06/12/2015 Expires: 09/30/2020 management activities to ensure the individual receives tuberculosis services.

# Early Intervention Services for HIV (for "Designated States" Only)

| 1.    | disord  | Does your state currently maintain an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIC in areas that have the greatest need for such services and monitoring the service delivery? |              |  |  |  |
|-------|---|---|--------------|--|--|--|
| 2.    | Are yo  | Are you considering any of the following:   |              |  |  |  |
|       | a)  | Establishment of EIS-HIV service hubs in rural areas  | jn Yes jn No |  |  |  |
|       | b)  | Establishment or expansion of tele-health and social media support services   | jn Yes jn No |  |  |  |
|       | c)  | Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS  | jn Yes jn No |  |  |  |
| Syrin | Syringe Service Programs  |   |              |  |  |  |
| 1.    | Does your state have in place an agreement to ensure that SABG funds are not expended to provide individuals with hypodermic needles or syringes(42 U.S.C§ 300x-31(a)(1)F)? |   |              |  |  |  |
| 2.    | Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle<br>Exchange) Program?   |   |              |  |  |  |
| 3.    | Do any of the programs use SABG funds to support elements of a Syringe Services Program?  |   |              |  |  |  |

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

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

## Narratve Question

# Criterion 8,9&10

Syringe System Needs

Does your state have in place an agreement to ensure that the state has conducted a statewide assessment jn Yes in No 1. of need, which defines prevention and treatment authorized services available, identified gaps in service, and outlines the state's approach for improvement

#### 2. Are you considering any of the following:

|                   |       | a)   | Workforce development efforts to expand service access   |              |  |  |
|-------------------|-------|--|--|--------------|--|--|
|                   |       | <ul> <li>Establishment of a statewide council to address gaps and formulate a strategic plan to coordina<br/>services</li> </ul> |  |              |  |  |
|                   |       | c)   | Establish a peer recovery support network to assist in filling the gaps  | jn Yes jn No |  |  |
|                   |       | d)   | Incorporate input from special populations (military families, service memebers, veterans, tribal entities, older adults, sexual and gender minorities)  | jn Yes jn No |  |  |
|                   |       | e)   | Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, i.e. primary healthcare, public health, VA, community organizations   | jn Yes jn No |  |  |
|                   |       | f)   | Explore expansion of service for:  |              |  |  |
|                   |       |  | i) MAT   | ja Yes ja No |  |  |
|                   |       |  | ii) Tele-Health  | ja Yes ja No |  |  |
|                   |       |  | iii) Social Media Outreach   | ja Yes ja No |  |  |
|                   | Servi | ce Coor  | rdination  |              |  |  |
|                   | 1.    |  | our state have a current system of coordination and collaboration related to the provision of person red and person-directed care?   | jn Yes jn No |  |  |
|                   | 2.    | Are yo   | u considering any of the following:  |              |  |  |
|                   |       | a)   | Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services  | jn Yes jn No |  |  |
|                   |       | b)   | Establish a program to provide trauma-informed care  | ja Yes ja No |  |  |
|                   |       | c)   | Identify current and perspective partners to be included in building a system of care, e.g. FQHCs, primary healthcare, recovery community organizations, juvenile justice systems, adult criminal justice systems, and education | j∩ Yes j∩ No |  |  |
| Charitable Choice |       |  |  |              |  |  |
|                   | 1.    |  | our state have in place an agreement to ensure the system can comply with the services provided by vernment organizations (42 U.S.C.§ 300x-65, 42 CF Part 54 (§54.8(b) and §54.8(c)(4)) and 68 FR 56430-                         | jn Yes jn No |  |  |
|                   | 2.    | Are yo   | u considering any of the following:  |              |  |  |
|                   |       | a)   | Notice to Program Beneficiaries  | ja Yes ja No |  |  |
|                   |       | b)   | Develop an organized referral system to identify alternative providers   | ja Yes ja No |  |  |
|                   |       | a)   | Develop a system to maintain a list of referrals made by religious organizations   | ja Yes ja No |  |  |
|                   | Refer | rals   |  |              |  |  |
|                   |       |  | oes your state have an agreement to improve the process for referring individuals to the treatment nodality that is most appropriate for their needs?  |              |  |  |
|                   | 2.    | Are yo   | u considering any of the following:  |              |  |  |
|                   |       | a)   | Review and update of screening and assessment instruments  | ja Yes ja No |  |  |
|                   |       | b)   | Review of current levels of care to determine changes or additions   | ja Yes ja No |  |  |
|                   |       |  |  |              |  |  |

## Printed: 8/30/2017 4:04 PM - Washington - OMB No. 0930-0168 Approved: 06/12/2015 Expires: 09/30/2020

|       | c)   | Identify workforce needs to expand service capabilities  |              |  |
|-------|--|--|--------------|--|
|       | d)   | Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background                    | jn Yes jn No |  |
| Patie | ent Rec  | ords   |              |  |
| 1.    | Does   | your state have an agreement to ensure the protection of client records?   | ja Yes ja No |  |
| 2.    | Are yo   | e you considering any of the following:  |              |  |
|       | a)   | Training staff and community partners on confidentiality requirements  | jn Yes jn No |  |
|       | b)   | Training on responding to requests asking for acknowledgement of the presence of clients   | jn Yes jn No |  |
|       | c)   | Updating written procedures which regulate and control access to records   | jn Yes jn No |  |
|       | d)   | Review and update of the procedure by which clients are notified of the confidentiality of their records include the exceptions for disclosure | jn Yes jn No |  |
| Inde  | pender   | nt Peer Review   |              |  |
| 1.    | Does your state have an agreement to assess and improve, through independent peer review, the quality $j$ Yes j No |  |              |  |

2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C.§ 300x-52(a)) and 45 § CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program

> Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.

The state completes an annual independent peer review of its providers. The BHOs and FIMC are required to submit the names of providers who will be reviewed as well as independent peer reviewers from each of the regions in the state. The state has an administrative policy in place that defines the purpose and scope of the reviews. This year 25 substance abuse providers and 11 mental health providers have been reviewed, the state expects to review the same number of providers in FFY18 and FFY19. However, the number of providers may change depending on the number contractors the BHOs and FIMC have who receive block grant funding.

Are you considering any of the following: 3.

4.

involved.

| a)     | Development of a quality improvement plan   | jn Yes jn No |
|--------|---|--------------|
| b)     | Establishment of policies and procedures related to independent peer review   | jn Yes jn No |
| c)     | Develop long-term planning for service revision and expansion to meet the needs of specific populations   | jm Yes jm No |
| indepe | our state require a block grant sub-recipient to apply for and receive accreditation from an<br>endent accreditation organization, e.g., Commission on the Accreditation of Rehabilitation Facilities<br>, The Joint Commission, or similar organization as an eligibility criterion for block grant funds? | jn Yes jn No |

If YES, please identify the accreditation organization(s)

and appropriateness of treatment services delivered by providers?

- i) Commission on the Accreditation of Rehabilitation Facilities ê
- ii) The Joint Commission ê
- iii) Other (please specify) Ð

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

# Criterion 7&11

**Group Homes** 

- 1. Does your state have an agreement to provide for and encourage the development of group homes for  $j \cap Y_{es} j \cap N_{os}$  persons in recovery through a revolving loan program?
- 2. Are you considering any of the following:
  - a) Implementing or expanding the revolving loan fund to support recovery home development as part jn Yes jn No of the expansion of recovery support service
  - b) Implementing MOUs to facilitate communication between block grant service providers and group j∩ Yes j∩ No homes to assist in placing clients in need of housing

## **Professional Development**

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opertunity to receive training on an ongoing basis, concerning:

| a)    | Recent trends in substance use disorders in the state   | jn Yes in No |
|-------|---|--------------|
| b)    | Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services  | jn Yes jn No |
| c)    | Preformance-based accountability  | jn Yes in No |
| d)    | Data collection and reporting requirements  | jn Yes in No |
| Are y | ou considering any of the following:  |              |
| a)    | A comprehensive review of the current training schedule and identification of additional training needs   | jn Yes jn No |
| b)    | Addition of training sessions designed to increase employee understanding of recovery support services  | jn Yes jn No |
| c)    | Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services  | jn Yes jn No |
| d)    | State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort | jn Yes jn No |

#### Waivers

1.

2.

Upon the request of a state, the Secretary may waive the requirements of all or part of the sections 1922(c), 1923, 1924. and 1928 (42 U.S.C.§ 300x-32 (f)).

|    | 10 900 |   |              |  |  |
|----|--------|---|--------------|--|--|
|    | a)     | Allocations regarding women   | jm Yes jm No |  |  |
| 2. | Requir | rements Regarding Tuberculosis Services and Human Immunodeficiency Virus: |              |  |  |
|    | a)     | Tuberculosis  | jm Yes jm No |  |  |
|    | b)     | Early Intervention Services Regarding HIV                                 | ja Yes ja No |  |  |
| 3. | Additi | onal Agreements   |              |  |  |
|    | a)     | Improvement of Process for Appropriate Referrals for Treatment            | jm Yes jm No |  |  |
|    | b)     | Professional Development  | ja Yes ja No |  |  |
|    | c)     | Coordination of Various Activities and Services                           | ja Yes ja No |  |  |
|    |        |   |              |  |  |

Please provide a link to the state administrative regulations, which govern the Mental Health and Substance Use Disorder Programs.

Is your state considering requesting a waiver of any requirements related to:

http://app.leg.wa.gov/RCW/default.aspx?cite=70.96A&full=true

Mental Health http://app.leg.wa.gov/RCW/default.aspx?Cite=71

# 12. Quality Improvement Plan- Requested

## Narrative Question

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

## Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2016-FFY 2017?

jn Yes in No

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

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

## 13. Trauma - Requested

## Narrative Question

<u>Trauma</u><sup>60</sup> is a widespread, harmful, and costly public health problem. It occurs because of violence, abuse, neglect, loss, disaster, war and other emotionally harmful and/or life threatening experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in behavioral health. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated behavioral health problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions. Schools are now recognizing that the impact of exposure to trauma and violence among their students makes it difficult to learn and meet academic goals. Communities and neighborhoods experience trauma and violence. For some these are rare events and for others these are daily events that children and families are forced to live with.

These children and families remain especially vulnerable to trauma-related problems, often are in resource poor areas, and rarely seek or receive behavioral health care. States should work with these communities to identify interventions that best meet the needs of these residents. In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink doing "business as usual." These public institutions and service settings are increasingly adopting a trauma-informed approach. A trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to these appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma<sup>61</sup> paper.

60 Definition of Trauma: Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being. 61 Ibid

## Please respond to the following items

| 1. | Does the state have a plan or policy for behavioral health providers that guide how they will address individuals with trauma-related issues?      | ja Yes ja No |
|----|--|--------------|
| 2. | Does the state provide information on trauma-specific assessment tools and interventions for behavioral health providers?                          | jn Yes in No |
| 3. | Does the state have a plan to build the capacity of behavioral health providers and organizations to implement a trauma-informed approach to care? | ja Yes ja No |
| 4. | Does the state encourage employment of peers with lived experience of trauma in developing trauma-<br>informed organizations?                      | ja Yes ja No |

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

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

# 14. Criminal and Juvenile Justice - Requested

## Narrative Question

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one-third meet criteria for having co-occurring mental and substance use problems. Youth in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.<sup>62</sup>

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention

Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.<sup>63</sup>

A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with M/SUD from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment Medicaid and/or Marketplace; loss of eligibility for Medicaid resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

The MHBG and SABG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

<sup>62</sup> Journal of Research in Crime and Delinquency: *Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice.* Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Renée L. Binder. <u>OJJDP Model Programs Guide</u>
 <sup>63</sup> <u>http://csgiusticecenter.org/mental-health/</u>

## Please respond to the following items

| 1. | Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems<br>on diversion of individuals with mental and/or substance use disorders from incarceration to community<br>treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to<br>behavioral health services? | jn Yes jn No |
|----|---|--------------|
| 2. | Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, behavioral health provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms?                     | jn Yes jn No |
| 3. | Does the state provide cross-trainings for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?  | jn Yes jn No |

- 4. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and jon Yes jon No juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address behavioral health and other essential domains such as employment, education, and finances?
- 5. Does the state have any activities related to this section that you would like to highlight?

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

## 15. Medication Assisted Treatment - Requested

## Narrative Question

There is a voluminous literature on the efficacy of medication-assisted treatment (MAT); the use of FDA approved medication; counseling; behavioral therapy; and social support services, in the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for MAT for SUDs is described in SAMHSA TIPs 40[1], 43[2], 45[3], and 49[4].

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to use MAT or have collaborative relationships with other providers that can provide the appropriate MAT services clinically needed.

Individuals with substance use disorders who have a disorder for which there is an FDA approved medication treatment should have access to those treatments based upon each individual patient's needs. In addition, SAMHSA also encourages states to require the use of MAT for substance use disorders for opioid use, alcohol use, and tobacco use disorders where clinically appropriate. SAMHSA is asking for input from states to inform SAMHSA's activities.

## Please respond to the following items:

| 1. |  | Has the state implemented a plan to educate and raise awareness within SUD treatment programs $j \cap$ Yes $j \cap$ No regarding MAT for substance use disorders?       |  |              |  |  |  |
|----|--|---|--|--------------|--|--|--|
| 2. |  | Has the state implemented a plan to educate and raise awareness of the use of MAT within special target $j \cap Yes j \cap No$ audiences, particularly, pregnant women? |  |              |  |  |  |
| 3. | Does t   | the stat  | e purchase any of the following medication with block grant funds? | ja Yes ja No |  |  |  |
|    | a) 🚊 Methadone   |   |  |              |  |  |  |
|    | b) e Buprenophine, Buprenorphine/naloxone  |   |  |              |  |  |  |
|    | c)   | ê   | Disulfiram   |              |  |  |  |
|    | d)   | ē   | Acamprosate  |              |  |  |  |
|    | e) 🗧 Naltexone (oral, IM)  |   |  |              |  |  |  |
|    | f)   | ē   | Naloxone   |              |  |  |  |
| 4. | Does the state have an implemented education or quality assurance program to assure that evidence-<br>based MAT with the use of FDA-approved medications for treatment of substance abuse use disorders are<br>used appropriately? |   |  |              |  |  |  |
| 5. | Does the state have any activities related to this section that you would like to highlight?   |   |  |              |  |  |  |

Please indicate areas of technical assistance needed to this section.

\*Appropriate use is defined as use of medication for the treatment of a substance use disorder, combining psychological treatments with approved medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, and advocacy with state payers.

## 16. Crisis Services - Requested

## Narrative Question

In the on-going development of efforts to build an robust system of evidence-based care for persons diagnosed with SMI, SED and SUD and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from behavioral health crises. SAMHSA has recently released a publication, Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies that states may find helpful.<sup>64</sup> SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with behavioral health conditions and their families.

# According to SAMHSA's publication, Practice Guidelines: Core Elements for Responding to Mental Health Crises<sup>65</sup>,

"Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination, and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective communitybased crisis-prevention and response systems. Given the multi-system involvement of many individuals with behavioral health issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The following are an array of services and supports used to address crisis response. Please check those that are used in your state:

## <sup>64</sup>http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848

<sup>65</sup>Practice Guidelines: Core Elements for Responding to Mental Health Crisis. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427

## Please respond to the following items:

| 1. | Crisis Prevention and Early Intervention |                  |  |
|----|--|------------------|--|
|    | a)                                       | ê                | Wellness Recovery Action Plan (WRAP) Crisis Planning   |
|    | b)                                       | ê                | Psychiatric Advance Directives   |
|    | c)                                       | ê                | Family Engagement  |
|    | d)                                       | ē                | Safety Planning  |
|    | e)                                       | ē                | Peer-Operated Warm Lines   |
|    | f)                                       | ē                | Peer-Run Crisis Respite Programs   |
|    | g)                                       | ê                | Suicide Prevention   |
| 2. | <u>Crisis</u>                            | Interver         | ntion/Stabilization  |
|    |  |                  |  |
|    | a)                                       | ê                | Assessment/Triage (Living Room Model)  |
|    | a)<br>b)                                 | ê                | Assessment/Triage (Living Room Model)<br>Open Dialogue   |
|    | ,  | -                |  |
|    | b)                                       | ê                | Open Dialogue  |
|    | b)<br>c)                                 | ê                | Open Dialogue<br>Crisis Residential/Respite  |
|    | b)<br>c)<br>d)                           | ê<br>ê           | Open Dialogue<br>Crisis Residential/Respite<br>Crisis Intervention Team/Law Enforcement  |
| 3. | b)<br>c)<br>d)<br>e)<br>f)               | ê<br>ê<br>ê<br>ê | Open Dialogue<br>Crisis Residential/Respite<br>Crisis Intervention Team/Law Enforcement<br>Mobile Crisis Outreach  |
| 3. | b)<br>c)<br>d)<br>e)<br>f)               | ê<br>ê<br>ê<br>ê | Open Dialogue<br>Crisis Residential/Respite<br>Crisis Intervention Team/Law Enforcement<br>Mobile Crisis Outreach<br>Collaboration with Hospital Emergency Departments and Urgent Care Systems |

- c) 🗧 Follow-up Outreach and Support
- d) 🗧 Family to Family Engagement
- e) E Connection to care coordination and follow-up clinical care for individuals in crisis
- f) E Follow-up crisis engagement with families and involved community members
- g) e Recovery community coaches/peer recovery coaches
- h) e Recovery community organization
- 4. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed to this section.

# 17. Recovery - Required

## Narrative Question

The implementation of recovery supports and services are imperative for providing comprehensive, quality behavioral health care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of: health (access to quality health and behavioral health treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual?s mental or substance use disorder. Because mental and substance use disorders are chronic conditions, systems and services are necessary to facilitate the initiation, stabilization, and management of long-term recovery. SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders: Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- · Recovery emerges from hope;
- · Recovery is person-driven;
- · Recovery occurs via many pathways;
- · Recovery is holistic;
- · Recovery is supported by peers and allies;
- · Recovery is supported through relationship and social networks;
- · Recovery is culturally-based and influenced;
- · Recovery is supported by addressing trauma;
- · Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

## Please see SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders.

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Examples of evidence-based and emerging practices in peer recovery support services include, but are not limited to, the following:

- Clubhouses
- Drop-in centers
- Recovery community centers
- Peer specialist
- Peer recovery coaching
- Peer wellness coaching
- · Peer health navigators
- Family navigators/parent support partners/providers
- Peer-delivered motivational interviewing

- Peer-run respite services
- · Peer-run crisis diversion services
- Telephone recovery checkups
- Warm lines
- · Self-directed care
- · Supportive housing models
- Evidenced-based supported
   employment
- Wellness Recovery Action Planning (WRAP)

- Whole Health Action Management (WHAM)
- Shared decision making
- Person-centered planning
- · Self-care and wellness approaches
- Peer-run Seeking Safety groups/Wellness-based community campaign
- Room and board when receiving treatment

SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery

Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recoveryoriented supports, services, and systems for people in recovery from substance use and/or mental disorders. Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

## Please respond to the following:

1. Does the state support recovery through any of the following:

| a) | Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care? | ja Yes ja No |
|----|--|--------------|
| b) | Required peer accreditation or certification?  | jn Yes jn No |
| c) | Block grant funding of recovery support services.  | in Yes in No |

d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system?

DBHR recognizes recovery support services as important adjuncts in helping ensure individuals in recovery from substance use disorder or mental illness 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 individuals with lived experience can identify realistic goals, prioritize steps to meet goals, and select services to aid them on their path to recovery.

- 2. Does the state measure the impact of your consumer and recovery community outreach activity?
- 3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

The Permanent Options for Recovery-Centered Housing (PORCH) project and the Bringing Recovery into Diverse Groups through Engagement and Support (BRIDGES) provides the evidence-based practice Permanent Supportive Housing (PSH) and Supported Employment (SE). The target population is adults, who are homeless or chronically 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 and BRIDGES projects are a partnership between DBHR, three 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 and SE project teams provide housing-related support services and other assistance, 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 PSH model.

Another initiative to supporting recovery in the past ten years has been Washington State's Project for Assistance in Transition from 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.

PATH programs are limited to conduct outreach and enroll homeless individuals who may have a mental illness or co-occurring substance use disorder. The PATHFINDER project funded by the State's Targeted Response to the Opiate Crisis grant will enhance the outreach efforts of PATH teams for the most vulnerable segment of our homeless population by adding Substance Use Disorder (SUD) Peers to seek out those that are opiate addicted and living in areas not fit for human habitation. Evidence indicates that substance use disorders are known risk factors for homelessness. (Susser E, 1993) Data clearly shows that substance use disorders and overdoses disproportionately impact homeless people. Through the PATHFINDER resources, two peers will be attached to each outreach team throughout the ten regions.

Washington State's Peer Support Program has trained and qualified mental health consumers as Certified Peer Counselors since 2005. Peer services are included as a Medicaid reimbursable service in the mental health section of the State Plan. Certified Peer Counselors work with their peers (adults and youth) and the families of children receiving mental health services. They draw upon their experiences to help peers find hope and make progress toward recovery. Because of their own life experience, they are uniquely equipped to provide support, encouragement, and resources to those with behavioral health challenges. The certification program has been adapted to be inclusive of consumers with substance use challenges however, there currently is not any funding mechanism to reimburse for SUD peer services. The PATHFINDER project is an opportunity to demonstrate the effectiveness of SUD peer services while strategizing steps to fund SUD peer services to address the critical need for outreach and

engagement of individuals with opiate addictions who experience homelessness. Printed: 8/30/2017 4:04 PM - Washington - OMB No. 0930-0168 Approved: 06/12/2015 Expires: 09/30/2020 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 in 2013, 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 to take 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 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 1,000 individuals across the three sites. The 'bridge' subsidy may include application fees, security deposits, utilities assistance, and rent. In 2016, mental health block grant funds were used to expand from three teams to seven. Additional resources from the Legislature provided funds for additional subsidies for the four new teams.

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

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, where individuals with lived experience select support services to aid them on their path to recovery from a menu of available services.

DBHR supports the efforts of over 253 Oxford Houses in Washington State (approximately 2,074 beds based on each house having 8.3 residents covering 22 counties). The Oxford Housing provided sober housing to 8,564 individuals last biennium. 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 \$400/month. The houses are gender specific and some homes 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 on how to establish new chapters, and how to keep the Oxford Houses a safe place of recovery.

5. Does the state have any activities that it would like to highlight?

#### Employment

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 originally sponsored by SAMHSA in 2014 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.

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. 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

## Printed: 8/30/2017 4:04 PM - Washington - OMB No. 0930-0168 Approved: 06/12/2015 Expires: 09/30/2020

illness obtain and maintain competitive employment. The pilot program in Snohomish and Skagit counties focuses on serving individuals with co-occurring mental health and substance use disorder issues who receive TANF with a subset of individuals who are homeless or at risk of becoming homeless. DBHR implemented the pilot in partnership with the Economic Services Administration, Gates Foundation/Snohomish County through their System Change Funds 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 are 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 North Central BHO and Columbia River Mental Health in the Southwest Washington fully integrated managed care region will implement the project, known as Becoming Employed Starts Today (BEST).

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

## 18. Community Living and the Implementation of Olmstead - Requested

## Narrative Question

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in <u>Olmstead v. L.C., 527 U.S.</u> <u>581 (1999)</u>, provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of M/SUD on America's communities. Being an active member of a community is an important part of recovery for persons with behavioral health conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with behavioral health needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office for Civil Rights (OCR) cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

## Please respond to the following items

| 1. | Does the state's Olmstead plan include :  |              |
|----|---|--------------|
|    | housing services provided.  | jn Yes jn No |
|    | home and community based services.  | ja Yes ja No |
|    | peer support services.  | ja Yes ja No |
|    | employment services.  | jn Yes jn No |
| 2. | Does the state have a plan to transition individuals from hospital to community settings? | jn Yes jn No |

3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

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

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

## 19. Children and Adolescents Behavioral Health Services - Required MHBG, Requested SABG

## Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community<sup>66</sup>. Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24<sup>67</sup>. For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death<sup>68</sup>.

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21<sup>69</sup>. Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs<sup>70</sup>.

According to data from the 2015 Report to Congress<sup>71</sup> on systems of care, services:

- 1. reach many children and youth typically underserved by the mental health system;
- 2. improve emotional and behavioral outcomes for children and youth;
- 3. enhance family outcomes, such as decreased caregiver stress;
- 4. decrease suicidal ideation and gestures;
- 5. expand the availability of effective supports and services; and
- 6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious behavioral health needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and employment); and

• residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

66 Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

<sup>67</sup>Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593?602.

<sup>68</sup>Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

69 The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

<sup>70</sup>Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from <u>http://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings/PEP12-CMHI2010</u>

<sup>71</sup> <u>http://www.samhsa.gov/sites/default/files/programs\_campaigns/nitt-ta/2015-report-to-congress.pdf</u>

#### Please respond to the following items:

3.

5

Does

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

| a) The recovery and resilience of children and youth with SED? | ja Yes ja No |
|--|--------------|
| b) The recovery and resilience of children and youth with SUD? | n Yes in No  |

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address behavioral health needs:

|      | a) Child welfare?  | jn Yes jn No |
|------|--|--------------|
|      | b) Juvenile justice?                                     | ja Yes ja No |
|      | c) Education?  | ja Yes ja No |
| s th | ne state monitor its progress and effectiveness, around: |              |
|      | a) Service utilization?                                  | jn Yes jn No |
|      |  |              |

| b) Costs?                                    | jn Yes jn No |
|--|--------------|
| c) Outcomes for children and youth services? | jn Yes in No |

4. Does the state provide training in evidence-based:

| a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families? | jn Yes jn No |
|---|--------------|
| b) Mental health treatment and recovery services for children/adolescents and their families?                     | jn Yes jn No |
| Does the state have plans for transitioning children and youth receiving services:                                |              |
| a) to the adult behavioral health system?   | jn Yes jn No |

b) for youth in foster care? jn Yes jn No

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

The Family Youth System Partner Round Table (FYSPRT) provides leadership to influence the establishment and sustainability of Children's Behavioral Health principles statewide. The Statewide and Regional FYSPRTs play a critical role, within the Children's Behavioral Health Governance Structure, in informing and providing oversight for high-level policy-making, program planning, decision-making, and for the implementation of the T.R. Settlement Agreement and statewide governance oversight of the State Youth Treatment – Implementation (SYT-I) grant and Recovery Supports initiative. In alignment with the Children's Behavioral Health Principles, the Statewide and Regional FYSPRT recommends strategies to provide behavioral health services and supports for children and youth as well as monitor and review both process and outcome indicators including Wraparound with Intensive Services outcome and performance data. The FYSPRTs support System of Care values including 1) Family driven and youth guided, 2) cultural and linguistic appropriate services and 3) community based services and support the goals of the Washington State system of care:

- 1) Infuse system of care principles in all child and youth serving systems.
- 2) Expand and sustain effective leadership roles for families, youth, and system partners.
- 3) Establish an appropriate array of services and resources statewide, including home-and community-based services.

#### Printed: 8/30/2017 4:04 PM - Washington - OMB No. 0930-0168 Approved: 06/12/2015 Expires: 09/30/2020

4) Develop and strengthen a workforce that will operationalize children's behavioral health principles.

- 5) Build a strong data management system to inform decision-making and track outcomes.
- 6) Develop sustainable financing and align funding to ensure services are seamless for children, youth, and families.

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

• Legislative direction for the creation of Behavioral Health Organizations which began in April 2016. Behavioral Health Organizations took lead in integrating Substance Use Disorder services into managed care with mental health services. This process is the first step to full purchasing integration with physical and behavioral health services.

• Implementation of Wraparound with Intensive Services (WISe) emphasizes a wraparound approach to both high-level and other level need youth cases, adopting the Child and Adolescent Needs and Strengths (CANS) assessment tool to evaluate needs and strengths in multiple domains. Access to Care Standards highlights the need to evaluate functional need in all domains.

• Roll out of Washington State's First Episode Psychosis Initiative, placing emphasis on early intervention services for individuals experiencing early onset symptoms of schizophrenia.

• Family Peer Partner and Youth Peer Partner development in services and system development.

• As a part of our Washington Administrative Code (WAC) 388-877-0620 Clinical – Individual Service Plan outlines components required for mental health and substance use disorder treatment; including, but not limited to:

o Address age, gender, cultural, strengths and/or disability issues identified by the individual or, if applicable, the individual's parent(s) or legal representative.

o Use a terminology that is understandable to the individual and the individual's family.

o Demonstrate the individual's participation in the development of the plan.

o Document participation of family or significant others, if participation is requested by the individual and is clinically appropriate. o Be strength-based.

o Contain measurable goals or objectives, or both.

The state has established collaborations with other child and youth serving agencies in the state to address behavioral health needs as evidenced by the coordinated contracts with Children's Long Term Inpatient Program (CLIP) and Behavioral Health Organization regions. This effort has been strengthened by the System of Care Grant and T.R. Settlement driven Children's Behavioral Health Governance Structure including the Children's Behavioral Health Executive Leadership Team, the Statewide FYSPRT, and ten Regional FYSPRTs. The Statewide FYSPRT has a tribal representative and representatives from these six youth-serving state partners: Rehabilitation Administration-Juvenile Rehabilitation (RA), Department of Health (DOH), Children's Administration (CA), Health Care Authority (HCA), Office of Superintendent of Public Instruction (OSPI), and Developmental Disabilities Administration (DDA).

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

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

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

• Tracking evidence-based practice (EBP) reporting, and multiple input methods for WISe system rollout and CANs progress tracking.

· Following through the payment system (ProviderOne).

- · Using performance based contracting and contract monitoring.
- · Monitoring Children's Behavioral Health Measures.

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

#### Mental Health Services

A program agreement was established to coordinate activities that promote cross-systems collaboration between local public mental health providers and local education agencies (LEAs) to provide services and programs for students who are eligible for special education services under the Individuals with Disabilities Education Act (IDEA) and who are eligible for services through the DBHR.

## Prevention

Administered by the Washington State Office of Superintendent of Public Instruction (OSPI), federal Substance Abuse Prevention and Treatment block grant funds are awarded annually to regional Educational Service Districts. The Student Assistance Printed: 8/30/2017 4:04 PM - Washington - OMB No. 0930-0168 Approved: 06/12/2015 Expires: 09/30/2020 Prevention Intervention Services program places Student Assistance Specialists in schools in Community Prevention and Wellness Initiative locations to address problems associated with substance use violence and other non-academic barriers to learning. Student Assistance Specialists (SAP) are assigned to designated school sites to provide direct services to students who are at risk and/or harmfully involved with alcohol, tobacco, and other drugs. SAP services include:

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

#### Treatment

In 2015, two counties (one rural, one urban) piloted a project to address co-occurring disorders for students in a school-based setting. This project was in concert with the Office of Public School Instruction and focused on building capacity for the screening, assessment, referral, case management, and treatment to students with co-occurring disorders. This project enlisted a mental health professional, under the direct clinical supervision of a dually licensed chemical dependency and mental health professional, to serve a minimum of 50 youth with co-occurring needs. The direct services delivered are based on best practices identified by the University of Washington Evidence-Based Practice Institute.

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

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

# 20. Suicide Prevention - Required MHBG

## Narrative Question

Suicide is a major public health concern, it is the 10th leading cause of death overall, with over 40,000 people dying by suicide each year in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges behavioral health agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide through the use of MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the behavioral health agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

## Please respond to the following items:

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

in Yes in No

2. Describe activities intended to reduce incidents of suicide in your state.

The State Strategic Prevention Enhancement Plan addresses suicide prevention and mental health promotion through the efforts of an interagency workgroup that meets monthly in an effort to address the goals set forth in the plan. In January 2016, Governor Inslee's Executive Order 16-02 on firearm fatality and suicide prevention, tasked several state agencies with addressing these issues.

- The Office of the Superintendent of Public Instruction's Social Emotional Learning benchmarks group wrote guidelines and suggestions for new K-12 curricula.

- In October 2016, the Office of the Attorney General updated their white paper on firearm access by persons prohibited from possessing a firearm.

- In February 2017, the Office of Financial Management wrote a gap analysis on the WA firearm background check system.

- DOH formed two committees:

The Action Alliance for Suicide Prevention (AASP)

The Suicide Prevention Implementation (SPPI)

AASP is chaired by Secretary John Wiesman (DOH) and the goals are to prioritize recommendations from the suicide prevention plan, seek data, evaluate known and emerging strategies, and facilitate development of effective strategies by leveraging their networks to support efforts statewide. In February 2017, AASP supported Forefront with their suicide prevention awareness events during legislative session at the capital.

The SPPI Workgroup is an open group comprised of professionals, coalitions, state and local agencies, law enforcement and community representatives with expertise and experience in suicide prevention strategies. The group increases awareness of resources, promotes events, and increases collaborations.

DOH has a program named Suicide Prevention Works! that is funded through a Garret Lee Smith grant from the Substance Abuse and Mental Health Services Administration (SAMHSA). The program's focus areas are Grays Harbor, Pacific and possibly Clallam counties; Native American youth; and LGBTQ youth. The programs core requirement is to follow-up within 48 hours for youth seen in the emergency department for suicide risk. The county health officers in Grays Harbor and Pacific Counties have ordered all youth self-harm attempts coming to the attention of the emergency room be reported to the local health department.

In September 2016, DOH launched a youth suicide prevention social marketing campaign called Start a Convo, Save a Life. The goals are to encourage peer-to-peer support, teach students about warning signs, and provide examples for how to ask a friend about suicide. The grant also funded a short video titled One Conversation Saved My Life about two Washington high school students sharing their story. Some of the SAMHSA funds supported the 2016 and 2017 Higher Education and Suicide Prevention conferences and some money was given to the American Indian Health Commission to support seven coastal tribes with youth suicide prevention.

Beginning July 2017, DOH will partner with DBHR to offer:

- \$100,000 of state funding for youth suicide prevention mini-grants to communities.
- \$16,000 of state funding to support a suicide prevention track at DBHR's Fall Prevention Summit.

In FY2017, DOH received \$100,000 of state funding for suicide prevention, these funds were contracted out to the Safer Homes Task Force. This group promotes safe storage of medications and firearms and assists with training health professionals, firearm retailers, and the general community. The contract included developing online trainings and collateral materials, consulting with events in two counties with high suicide rates.

| 3. | Have you incorporated any strategies supportive of Zero Suicide?  | jn Yes jn No |
|----|---|--------------|
| 4. | Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments? | jn Yes jn No |
| 5. | Have you begun any targeted or statewide initiatives since the FFY 2016-FFY 2017 plan was submitted?  | ja Yes ja No |
|    | If so, please describe the population targeted.   |              |
|    | Does the state have any activities related to this section that you would like to highlight?  |              |
|    | Please indicate areas of technical assistance needed related to this section.   |              |
|    |   |              |

| For | httpc | otes: |
|-----|-------|-------|
| FUU | אוונ  | nes.  |

# 21. Support of State Partners - Required MHBG

## Narrative Question

The success of a state's MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with M/SUD who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to
  ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective factors for
  mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and SUDs, to ensure that they have the
  services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of homeland security/emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in behavioral health needs and/or impact persons with behavioral health conditions and their families and caregivers, providers of behavioral health services, and the state's ability to provide behavioral health services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in behavioral health.

## Please respond to the following items:

| 1. | Has your state added any new partners or partnerships since the last planning period?          | ja Yes ja No |
|----|--|--------------|
| 2. | Has your state identified the need to develop new partnerships that you did not have in place? | jn Yes jn No |

If yes, with whom?

N/A

3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilites Education Act.

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

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

Accordingly, the Division of Behavioral Health and Recovery (DBHR) coordinated efforts and partnered with Aging and Long Term Services Administration (ALTSA) and the Health Care Authority (HCA) to develop a Medicaid 1115 demonstration waiver to add supported housing and employment as Medicaid covered services. The partnership will create a benefit of targeted, supportive housing services for eligible Medicaid beneficiaries. These housing-related services do not include payment for room and board Medicaid funds will be used to pay for services that help Medicaid beneficiaries get and keep housing. The supportive housing

service package includes services that identify and assist individuals in obtaining appropriate housing and provide tenant support to maintain housing, and one-time supports necessary for individuals to avoid institutional settings and to transition into an apartment or home. The supportive housing benefit will not replace existing services currently available to eligible populations.

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

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

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

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

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

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

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

22. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application - Required MHBG

## Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council for adults with SMI or children with SED. To meet the needs of states that are integrating services supported by MHBG and SABG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as a Behavioral Health Advisory/Planning Council (BHPC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a BHPC, SAMHSA has created Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.<sup>72</sup>

# Planning Councils are required by statute to review state plans and implementation reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as an advocate for individuals with behavioral health problems. SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

#### <sup>72</sup>http://beta.samhsa.gov/grants/block-grants/resources

## Please respond to the following items:

- 1. How was the Council involved in the development and review of the state plan and report? Attach supporting documentation (e.g. meeting minutes, letters of support, etc...)
  - a) What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment and recovery services?

BHAC as a policy partner with DBHR has a role in the key decisions that affect the quality and effectiveness of the programs and services DBHR oversees. The FFY2018-19 block grant was sent to the council members to review prior to the July meeting and it was discussed in detail at the July 12th meeting. The council members requested additional time to review and provide feedback. The council provided feedback and many of the suggested changes were incorporated into the block grant application.

- b) Has the Council successfully integrated substance misuse prevention and treatment or cooccurring disorder issues, concerns, and activities into i
- 2.
   Is the membership representative of the service area population (e.g. ethnic, cultural, linquistic, rural, suburban, urban, older adults, families of young children)?
   j∩ Yes j∩ No
- 3. Please indicate the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

The Division of Behavioral Health and Recovery is committed to creating an effective partnership with individuals with lived experience to improve behavioral health services to individuals living with mental and substance use disorders by improving the development, evaluation, and monitoring of those services by individuals with lived experience and stakeholders. The Behavioral Health Advisory Council (BHAC) was formed in 2012 and meets six times per year. Its membership is comprised of 53 percent consumers and also includes many state partners and stakeholders from the Health Care Authority, Children's Administration, Long Term Care, Developmental Disabilities, Juvenile Rehabilitation, Department of Health, the Office of the Superintendent of Public Instruction, Behavioral Health Organizations, Tribes, and providers.

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

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

Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.<sup>73</sup>

<sup>73</sup>There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

August 14, 2017

Chris Imhoff, Director

Division of Behavioral Health & Recovery

Director Imhoff:

As Co-Chairs, of the Washington State DSHS/DBHR Behavioral Health Council, we are pleased to be able to provide support for the final draft of DBHR's Federal Block Grant Application. We will highlight some of the strengths and concerns noted during the review by the Behavioral Health Planning Council.

We are noting for the second time that if we could receive the draft application earlier than two days prior to a BHAC meeting, we think we would have a much more robust response from the membership. While DBHR was gracious in allowing members more time for feedback, we received a very limited response and we are working with DBHR Federal Block Grant staff to refine our process of reviewing the Block Grant such that we can have a more robust, appropriate, and meaningful response.

Areas of concern noted are:

- Minimal utilization of recovery based language
- Integrity of data utilized in report
- ACES and Trauma Informed Care not included
- Narrative regarding use of marijuana tax funds to support youth prevention work not included

Strengths noted include:

- Funding of Common Ground Academy
- Funding Student Assistance Prevention & Intervention Services
- Sustaining funding for the New Journey's pilot
- Increasing the number of adults receiving outpatient MH & SUD services
- Increasing the number of youth receiving outpatient MH & SUD services
- Implementation of performance-based contracting
- Funding for accreditation of Peer Counselors
- Increase the use of EBP's

• Decrease housing instability

In summary, as representatives of the BHAC, we attest the plan has been reviewed by the BHAC and should be submitted to SAHMSA. If you have questions, please contact us per information provided below.

Sincerely,

Jeben Bytos

Rebecca Bates, Co- Chair BHAC

Damhard BA

Beth Dannhardt, Co-Chair BHAC

# Behavioral Health Advisory Council Members

Start Year: 2018 End Year: 2019

| Name                     | Type of Membership  | Agency or Organization<br>Represented             | Address,Phone,<br>and Fax  | Email(if available)                |
|--------------------------|---|---|--|------------------------------------|
| Jeff Aldrich             | Individuals in Recovery (to include<br>adults with SMI who are receiving,<br>or have received, mental health<br>services) |   | 1830 Carpenter Rd<br>Se, #7 Lacey WA,<br>98503<br>PH: 360-972-2336 | supra2bcher@msn.com                |
| Kathleen Arnold          | State Employees   |   |  |                                    |
| Becky Bates              | Providers   |   | PH: 509-688-1124   | bbates@passagesfs.org              |
| Connie Batin             | Family Members of Individuals in<br>Recovery (to include family<br>members of adults with SMI)                            |   | WA,  |                                    |
| Jennifer Bliss           | State Employees   |   | WA,<br>PH: 360-725-3709  |                                    |
| Cary Brim Reid           | Individuals in Recovery (to include<br>adults with SMI who are receiving,<br>or have received, mental health<br>services) |   | WA,  |                                    |
| Cathy Callahan-<br>Clem  | Family Members of Individuals in<br>Recovery (to include family<br>members of adults with SMI)                            |   | 14216 NE 21st St<br>Bellevue WA, 98007<br>PH: 206-459-6467         | cathyc@smh.org                     |
| Carolyn Cox              | Parents of children with SED  |   | WA,<br>PH: 509-440-1142  | carolyn.cox97@yahoo.com            |
| Beth Dannhardt           | Providers   | Triumph Treatment Services                        | WA,  | bdannhardt@triumphtx.org           |
| Dakaota Fox              | Individuals in Recovery (to include<br>adults with SMI who are receiving,<br>or have received, mental health<br>services) |   | WA,  |                                    |
| Dakoda Foxx              | Parents of children with SED  |   | 2309 E 5th Main, B9<br>Puyallup WA, 98372<br>PH: 253-329-1141      | dakodafoxx@gmail.com               |
| Mark Freedman            | Others (Not State employees or providers)   |   | WA,  |                                    |
| Phillip Gonzalez         | Family Members of Individuals in<br>Recovery (to include family<br>members of adults with SMI)                            |   | 16907 13th Ave Crt E<br>Spanaway WA,<br>98387<br>PH: 253-531-5161  | gonzapa@dshs.wa.gov                |
| Dan Halpin               | State Employees   | Office of the Insurance<br>Commissioner           | PH: 360-725-7218   | danH@oic.wa.gov                    |
| Tory Clarke<br>Henderson | State Employees   | Department of Health                              | PH: 360-236-3522<br>FX: 360-236-3646                               | tory.henderson@doh.wa.gov          |
| Ron Hertel               | State Employees<br>PM - Washington - OMB No. 0930-01  | Office of Superintendent of Public<br>Instruction | P.O. Box 47200<br>Olympia WA, 98504<br>PH: 360-725-6050            | ron.hertel@k12.wa.us<br>Page 283 o |

PH: 360-725-6050 Printed: 8/30/2017 4:04 PM - Washington - OMB No. 0930-0168 Approved: 06/12/2015 Expires: 09/30/2020

| Linda Kehoe, Ed.D              | Individuals in Recovery (to include<br>adults with SMI who are receiving,<br>or have received, mental health<br>services) |   | 621 32nd St, #39<br>Bellingham WA,<br>98225<br>PH: 360-595-8547     | drlindakehoe@yahoo.com          |
|--------------------------------|---|---|---|---------------------------------|
| Steve Kutz                     | Federally Recognized Tribe<br>Representatives   |   | PH: 360-575-8277  | skutz.health@cowlitz.org        |
| Susan Kydd                     | Individuals in Recovery (to include<br>adults with SMI who are receiving,<br>or have received, mental health<br>services) |   | 4513 Lakeridge Dr E<br>Lake Tapps WA,<br>98391<br>PH: 206-940-0339  | susan.kydd@becu.org             |
| Vanessa Lewis                  | Individuals in Recovery (to include<br>adults with SMI who are receiving,<br>or have received, mental health<br>services) |   | 6486 19th St W, #B<br>Fircrest WA, 98466<br>PH: 253-830-4709        | vlewis@wapave.org               |
| Kimberly Miller                | Individuals in Recovery (to include<br>adults with SMI who are receiving,<br>or have received, mental health<br>services) |   | 4525 113th PI NE<br>Marysville WA, 98271<br>PH: 360-913-3624        | kimberly.miller.office@gmail.co |
| Taku Mineshita                 | State Employees   |   | WA,   |                                 |
| Mary O'Brien                   | Providers   | Yakima Valley Farm Workers  | 910 E. Mead Yakima<br>WA, 98903<br>PH: 509-453-1344                 | mary@yvfwc.org                  |
| Moira O'Crotty                 | Individuals in Recovery (to include<br>adults with SMI who are receiving,<br>or have received, mental health<br>services) |   | 5832 S Oakes St<br>Tacoma WA, 98409<br>PH: 253-365-2817             | cmosnana@yahoo.com              |
| Myra Paull                     | Individuals in Recovery (to include<br>adults with SMI who are receiving,<br>or have received, mental health<br>services) |   | 9601 Steilacoom Blvd<br>W Lakewood WA,<br>98409<br>PH: 253-666-3242 | mpaull@telecarecorp.com         |
| Annabelle Payne                | Providers   | Pend Orielle County   | 105 S Garden Ave<br>Newport WA, 99156<br>PH: 509-671-2323           | apayne@pendoreille.org          |
| Melody Pazolt                  | State Employees   |   |   |                                 |
| Pamala Sacks-<br>Lawlar        | State Employees   | Department of Social and Health<br>Services/Juvenile Rehabilitation | PH: 360-902-0881  | sackspa@dshs.wa.gov             |
| Kristina Sawyckyj-<br>Moreland | Individuals in Recovery (to include<br>adults with SMI who are receiving,<br>or have received, mental health<br>services) |   | 1830 9th Ave Seattle<br>WA, 98101<br>PH: 206-501-7262               | sawyckykristina@yahoo.com       |
| Mario Sweet-<br>Williams       | State Employees   |   |   |                                 |
| Kristin West                   | Providers   | Evergreen Council on Gambling                                       | PH: 360-352-6133  | kwest@evergreencpg.org          |
| Jo Ellen Woodrow               | Individuals in Recovery (to include<br>adults with SMI who are receiving,<br>or have received, mental health<br>services) |   | 11301 NE 7th St<br>#NN10 Vancouver<br>WA, 98684<br>PH: 509-701-4534 | gem2005su@yahoo.com             |

# Behavioral Health Council Composition by Member Type

Start Year: 2018 End Year: 2019

| Type of Membership  | Number | Percentage |
|---|--------|------------|
| Total Membership  | 32     |            |
| Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services) | 11     |            |
| Family Members of Individuals in Recovery* (to include family members of adults with SMI)                         | 3      |            |
| Parents of children with SED*   | 2      |            |
| Vacancies (Individuals and Family Members)  | 0      |            |
| Others (Not State employees or providers)   | 1      |            |
| Total Individuals in Recovery, Family Members & Others  | 17     | 53.12%     |
| State Employees   | 9      |            |
| Providers   | 5      |            |
| Federally Recognized Tribe Representatives  | 1      |            |
| Vacancies   | 0      |            |
| Total State Employees & Providers   | 15     | 46.88%     |
| Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ<br>Populations                                  | 0      |            |
| Providers from Diverse Racial, Ethnic, and LGBTQ Populations  | 0      |            |
| Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ<br>Populations                             | 0      |            |
| Persons in recovery from or providing treatment for or advocating for substance abuse services                    | 0      |            |

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

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

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

# 23. Public Comment on the State Plan - Required

## Narrative Question

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. § 300x-51) requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

# Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

| a) | Public meetings or hearings?  | jn Yes jn No        |
|----|---|---------------------|
| b) | Posting of the plan on the web for public comment?  | jn Yes jn No        |
| c) | Other (e.g. public service announcements, print media)  | ja Yes ja No        |
|    | If yes, provide URL:  |                     |
|    | https://www.dchs.wa.gov/sites/default/files/PHSIA/dbh/Stakeholder Notices/EEV2018_EEV2018_VA_ | Inified Plack Crant |

https://www.dshs.wa.gov/sites/default/files/BHSIA/dbh/Stakeholder Notices/FFY2018-FFY2019\_WA\_Unified\_Block\_Grant\_ Application.pdf