



FFY2018-FFY2019 WASHINGTON STATE UNIFIED BLOCK GRANT APPLICATION

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:

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

BHA operates 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

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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 (funded with State funds generated from the lottery)

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 fills which could put them at increased risk of hospitalization.
- Chronic health conditions of clients who are applying for SSI.
- Health services utilization (medical, behavioral health, long-term services and supports, 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.

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- 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 at 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 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, women who are pregnant and have a substance use and/or mental health disorder, and parents with substance use and/or mental health disorders who have dependent children.

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

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

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

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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 meet the Access to Care Standards 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 as well. 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

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remaining \$1.4 million in funding is allocated to the tribes based on a methodology of 30 percent population and 70 percent distributed evenly between the tribes.

Not only can Tribes contract with DBHR, but Tribes also have the opportunity and option to contract with Behavioral Health Organizations (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 abuse services. In addition, authorized Tribes can serve non-tribal members and receive 50 percent of the encounter rate for substance abuse 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, IHS Direct, Tribal 638, and Urban Indian Health Program (I/T/U) system of care worked together to implement the fee-for-service system for SUD and MH 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 scientifically proven strategies to prevent substance use, while at the same time recognizing the importance of local innovation to develop programs for specific populations and emerging problems.

Funding is primarily disseminated via:

- County 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.

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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 [Project SUCCESS link](#).

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

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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 FMIC, 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 FMIC 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

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families. There are currently 69 intensive inpatient residential providers with a total capacity of 2,146 slots. 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 slots. Each patient participating in this level of substance use disorder treatment receives a minimum of four hours of treatment per week.
- Recovery Houses provide personal care and treatment, with social, vocational, and recreational activities to aid with patient adjustment to abstinence, as well as job training, employment, or other community activities. There are currently five adult recovery house providers with a capacity of 58 beds statewide. Each patient participating in this level of substance use disorder treatment receives a minimum of five hours of treatment services per week.

Withdrawal management (aka Detox) 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 detox 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 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.

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- 2) Expand and sustain effective leadership roles for families, youth, and system partners.
- 3) Establish an appropriate array of services and resources statewide, including home-and community-based services.
- 4) Develop and strengthen a workforce that will operationalize children's behavioral health principles.
- 5) Build a strong data management system to inform decision-making and track outcomes.
- 6) Develop sustainable financing and align funding to ensure services are seamless for children, youth, and families.

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

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

The state has established collaborations with other child and youth serving agencies in the state to address behavioral health needs as evidenced by the coordinated contracts with Children's Long Term Inpatient Program (CLIP) and Behavioral Health Organization regions. This effort has been strengthened by the System of Care Grant and T.R. Settlement driven Children's Behavioral Health Governance Structure including the Children's Behavioral Health Executive Leadership Team, the Statewide FYSPT, and ten Regional FYSPTs. The Statewide FYSPT 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).

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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.

Beginning in July 2015, contractors were 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 for children to assist schools in assuring identified children are connected with available mental health and/or substance use treatment, and recovery support services. All of these programs have been developed in coordination with the Washington State Office of Superintendent of Public Instruction (OSPI):

Mental Health Services

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

Prevention

Administered by the Washington State Office of Superintendent of Public Instruction (OSPI), federal Substance Abuse Prevention and Treatment block grant funds are awarded annually to regional Educational Service Districts. The Student Assistance Prevention Intervention Services program places Student Assistance Specialists in schools in Community Prevention and Wellness Initiative locations to address problems associated with substance use violence and other non-academic barriers to learning.

Student Assistance Specialists (SAP) are assigned to designated school sites to provide direct services to students who are at risk and/or harmfully involved with alcohol, tobacco, and other drugs. SAP services include:

- Administer a uniform screening instrument to determine levels of substance use and mental health concerns;
- Individual and family counseling and interventions on student substance use;
- Peer support groups to address student and/or family substance use issues;
- Coordinate and make referrals to treatment and other social service providers; and,

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

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

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Crisis Services

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

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

When involuntary treatment is indicated, either a designated chemical dependency specialist or a designated mental health professional investigate and evaluate facts alleging that a person would be better served through the Involuntary Treatment Act. If the designated chemical dependency specialist determines that the facts are reliable and credible, the specialist may file a petition for commitment of such a person with the superior or district court. The designated mental health professional will determine if an individual manifests mental health behaviors and symptoms that suggest the individual is at risk for harm to self or others or is gravely disabled without a mandatory treatment intervention.

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).

Fidelity reviews, conducted annually, adhere to the principles of the SAMHSA evidence-based practice model.

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.

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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) in DBHR currently has a team of five and will be adding three additional staff who have various types of experience/perspectives as individuals with lived experience of behavioral health systems in the state. The members provide voice for children and adult mental

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health and substance use disorder services. The OCP is a priority within DBHR with a clearly defined purpose. Some key elements include:

- Providing leadership as a member of the Executive Management Team.
- Advocating for both substance use disorder and mental health 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

Recent legislative changes within the Washington State Behavioral Health System, ongoing communication, collaboration, consultation and meeting and conferring with the Tribes and Urban Indian Health Program, as applicable, is of utmost importance. As the state transitions into managed care, and the tribal behavioral health system remains in the fee-for-service 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 include:

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

DBHR provides 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 is also 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

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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 in partnership with other DSHS Administrations (DBHR, Division of Vocational Rehabilitation, Aging and Long-Term Support, Rehabilitation Administration and the Office of Diversity and Inclusion) to bring together professionals from the diverse fields of social work, mental health, substance use disorder treatment, and substance abuse prevention. It focuses 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 will speak to 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. In addition to the keynote speaker, workshops will be offered to increase and encourage awareness, communication, and improve service delivery for LGBTQ individuals of all ages. Presenters will also share how we can 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. It is anticipated that 350 consumers and consumer advocates, 80 DBHR staff, and 16 Behavioral Health Advisory Committee members will be 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. In 2014, a total of 658 people attended the conference with 298 youth making up 48 teams attended leadership workshops for developing and implementing prevention projects in their schools and communities. The majority (92%) of conference participants would recommend the conference to others. The Prevention Summit was

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held in 2015 since Washington, along with two other states, hosted the National Prevention Network (NPN) conference. Youth were encouraged to attend the NPN to create and implement a community project.

The youth 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. However, in FY2015 it was a follow-up to the NPN. This is a peer-to-peer conference for Washington youth teams focused on prevention services where teams can showcase their work and learn from each other.

Peer Support Training

Washington State's Peer Support Program began training mental health individuals with lived experience to become Certified Peer Counselors in 2005. 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.

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- 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

In 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 Specialty 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 one sixteen-bed secure detoxification facility to be operational by April 1, 2018. It further directs the department to create one additional facility per year until there is a total of nine facilities statewide. 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 for persons with COD as well as systems issues and payment/financing.

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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 abuse 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. Chaired by the DBHR Office Chief for Decision Support and Evaluation and the State Epidemiologist for Non-Infectious Conditions from the Department Health (DOH), the SEOW is comprised of epidemiologists from multiple state agencies and universities tasked with monitoring and improving the behavioral health of the population. DBHR is committed to ensure that tribal behavioral health needs 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 in ensuring 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

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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 has 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 small 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

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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, (e.g. utilization patterns, penetration and retention rates) were 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.

Current Priorities

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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 Youth Outpatient Substance Use Disorder Treatment

Priority 4: Increase Outpatient Substance Use Disorder Treatment for Adults

Issues around access, service timeliness, and penetration continue to be a focus of substance abuse 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 Outpatient Mental Health Services for Adults with SMI

Priority 8: Increase Outpatient Services for Children 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: Maintaining 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: Provide recovery supports services, including housing and employment services 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:

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- Improvement in client health status
- Increases in client 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 **Results Washington**, which is Washington Governor Jay Inslee's data-driven performance management and continuous improvement system. Within Results Washington, DBHR has lead responsibility for six success metrics under the Healthy Youth and Adults success indicator in Goal Area 4 (Healthy and Safe Communities). Strategies to address each will be detailed later in the Priority, Goals, and Strategies of this application. 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 serviced 22,524 adults. However, the state is still resolving issues with completeness of detox and inpatient data after implementation of the BHOs.

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- 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.

ENVIROMENTAL FACTORS

Section 1: THE HEALTH CARE SYSTEM

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 healthcare is managed through health plan managed care contracts. These contracts integrate the financing of physical and behavioral healthcare and include value-based payment to drive innovation and clinical integration at the practice level. One of nine regional service areas (RSAs) implemented integrated managed care (IMC) in April 2016. A second region will implement IMC in January 2018, with the remaining regions following suit by 2020.

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 IMC is 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. 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 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

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provide as much clarity and flexibility within our current laws, funding, and state plan to support co-occurring delivery models.

Section 4: Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI)

The state partnered with the Washington Council for Behavioral Health (WCBH) in May 2016 to begin the groundwork to make policy recommendations in the 2017-2019 Biennium. WCBH organized and conducted a policy summit with executive branch policy leaders to increase 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 Pilot. 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.

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 has also supported the start-up of two additional sites in Thurston-Mason and King Counties. 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.

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.

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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 to improve the implementation and program development process.

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.
- 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.

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

In FFY2018 and FFY2019, WSU will collaborate with the Washington State DSHS, Research and Data Analysis (RDA) Division 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.

Diagnostic categories for ESMI include:

Age Range	15-25, with exceptions made up to 40 years old, based on clinical judgment and the New Journeys Model
Diagnoses	Schizophrenia, Schizoaffective Disorder, Schizophreniform Disorder, Brief Psychotic Disorder, or Psychotic Disorder not otherwise specified
Duration of Illness/Symptoms	> 1 week and < 2 years AND/OR < six months of lifetime treatment with antipsychotic medications Only one episode of psychosis (i.e., individuals with a psychotic episode followed by full symptom remission and relapse to another psychotic episode are excluded)
IQ	Over 70
Diagnostic Exclusions	Symptoms not known to be caused by a medical condition or drug use Autism

Section 5: Person Centered Planning (PCP)

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

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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.

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.

Section 7: PROGRAM INTEGRITY

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

DBHR also provides support and assistance to the Behavioral Health Organizations (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 in all subcontracts, this is 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 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.

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

Section 8: TRIBES

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

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protocols when policy, funding, services, and other changes affect American Indians (AI) and Alaska Natives (AN). The Department is committed to the establishment of inter-governmental 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 AI/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 in a fee-for-service (FFS) delivery system for Medicaid-eligible AI/AN. Additionally, tribal providers were able to directly refer their Medicaid-eligible AI/AN clients to non-tribal SUD and MH outpatient and inpatient providers within the FFS system. It is important to note that a AI/AN individual covered by Medicaid can choose to opt into the managed care system and receive SUD and MH services through the BHO system of providers; AI/AN individuals can also access care directly from an Indian Health Care Provider regardless of whether the provider is contracted with a BHO. While AI/AN individual has the option to choose Medicaid behavioral health care coverage under either managed care or the FFS system, it does impact the block grant funding that Tribes currently receive. DBHR is committed to continue providing block grant funding to 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 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 consult on the SAMHSA Combined Block Grant for tribal input.
- October 2015: DSHS, HCA, and Tribes formally consult on exempting Medicaid-eligible AI/ANs from SUD managed care services and remaining in the FFS system.
- April 2016: DBHR maintains SUD FFS system for Medicaid-eligible AI/AN.
- July 2016: DSHS and Tribes formally consult on the SAMHSA Combined Block Grant Biennial Plan for tribal input.
- October 2016: DSHS, HCA, and Tribes formally consult 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.
- June 26, 2017: DSHS and Tribes conducted the second roundtable discussion with Tribes.

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- July 14, 2017: DSHS and Tribes formally consult 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.

Section 9: PRIMARY Prevention

Assessment

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

Yes. Washington State has an active State Epidemiological Outcomes Workgroup (SEOW). The SEOW was first established in January 2005, as part of the Strategic Prevention Framework State Incentive Grant (SPF SIG), and has continued to meet quarterly. It is currently staffed by the Division of Behavioral Health and Recovery (DBHR) and core members include representatives from the Department of Social and Health Services (DBHR and Division of Research and Data Analysis), the Department of Health, Washington State Institute for Public Policy, the University of Washington and two tribal representatives.

The purpose of the SEOW is to support the development and use of robust and meaningful measures that allow data-driven policy decisions and program planning to prevent substance abuse and to promote mental health. The SEOW collects and provides guidance on the collection of data related to substance use and mental health, including consumption and prevalence, consequences of use, and intervening variables. Data sourced from both national and state surveys and administrative databases is collected statewide to cover all age and demographic groups. To allow for more in-depth geographic analysis, data are maintained at the lowest geographical level possible which allows Washington to support community-based initiatives.

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

Yes. This assessment includes data on:

- a. Long-term health and social consequences of substance-using behaviors
- b. Substance-using behaviors
- c. Intervening variables (risk and protective factors)
- d. Local contributing factors

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

- a. Washington collects needs assessment data on the following population groups:
 - i. Children (under age 12)
 - ii. Youth (ages 12-17)
 - iii. Young adults/college age (age 18-26)
 - iv. Adults (ages 27-54)
 - v. Older adults (age 55 and above)
 - vi. Gender and sex
 - vii. Cultural/ethnic minorities
 - viii. Sexual/gender minorities

ix. Rural communities

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

For its primary prevention needs assessment, Washington uses the following sources: the National Survey on Drug Use and Health, Behavioral Risk Factor Surveillance System, Youth Risk Behavior Surveillance System, and Monitoring the Future. Washington additionally uses two state-developed survey instruments: the Healthy Youth Survey and the Young Adult Health Survey.

The following Archival Indicators are used as well:

- 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
- 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. Polysubstance Misuse/Abuse (10th Grade)
 - viii. Sad/Hopeless in Past 12 Months (10th Grade)
 - ix. Suicide Ideation (10th Grade)
 - x. Suicide Plan (10th Grade)
 - xi. Suicide Attempt (10th Grade)
 - xii. Bullied/Harassed/Intimidated (10th Grade)
 - xiii. Source of Alcohol, Pain Killers Used to Get High; Marijuana; Vapor Products (10th Grade)
 - xiv. Perception of Availability of Alcohol, Marijuana, Cigarettes; Opioids (10th Grade)
 - xv. Risk Perception of Alcohol, Marijuana (10th Grade)
 - xvi. Knowledge of Laws, Perception of Enforcement – Alcohol, Marijuana (10th Grade)

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- 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?

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

Capacity Building

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

Yes. Through the Prevention Specialist Certification Board of Washington, the state provides a Certified Prevention Professional (CPP) credential. DBHR supports individuals in obtaining their CPP 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.

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

Yes. DBHR provides training and technical assistance for communities and prevention providers as they implement prevention services. There are currently 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.
 - These conferences provide educational and culturally competent training and networking opportunities for individuals and groups active in the field of prevention, including youth, volunteers, and prevention professionals. DBHR prevention staff participate both as presenters and attendees.
 - In calendar year 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.

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- **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.
 - 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:
 - The Strategic Prevention Framework Webinar Series, covering organization and governance, needs assessment, planning, implementation, and evaluation.
 - Evidence-based Program Trainings to provide training on specific prevention programs.
 - **DBHR Technical Assistance Training and On-going Support:**
 - 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
 - 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.
8. Does your state have a formal mechanism to assess community readiness to implement prevention strategies?

Yes. Washington has a formal mechanism to assess community readiness in collaboration with 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.

Planning

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

Yes. The current State of Washington Substance Abuse and Mental Health Promotion Five-Year Strategic Plan was developed in 2012 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.

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

Yes. Data prepared by the state SEOW supports the state's decision-making process regarding the use of the primary prevention set-aside of the SABG.

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

- a. The state's prevention strategic plan includes the following components:
 - i. The priorities that guide the allocation of SABG prevention funds are based on needs assessment datasets
 - ii. Timelines
 - iii. Roles and responsibilities
 - iv. Process indicators
 - v. Outcome indicators
 - vi. Cultural competence component
 - vii. Sustainability component
 - viii. Other:
 - 1. Resource assessment
 - 2. Prevention research theories

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

Yes. The Washington State Prevention Enhancement Policy Consortium (the Consortium) provides this function as does the Washington State Behavioral Health Advisory Committee (BHAC). The Consortium is comprised of representatives from 26 state and tribal agencies and organizations. The goal of the Consortium is that through partnerships, Washington will strengthen and support an integrated system of community-driven substance abuse prevention programming, mental health promotion programming, and programming for related issues.

The BHAC includes consumers, providers, advocates, government representatives, and other public and private entities and presents the state's population with respect to race, ethnicity, disability, age as well as urban and rural location. BHAC partners with DBHR in making decisions regarding the need, planning, operation, funding, and use of services for substance use disorders, mental health services and problem gambling.

13. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SABG primary prevention funds? If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based?

Yes. The State's Evidence-based Workgroup determines evidence-based practices and strategies. Membership includes representatives from the prevention research subcommittee,

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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.

Implementation

14. States distribute SABG primary prevention funds in a variety of different ways. Please check all that apply to your state:
 - a. The following apply in WA:
 - i. SSA staff directly implements primary prevention programs and strategies
 - ii. The SSA has statewide contracts
 - iii. The SSA funds regional entities to provide prevention services
 - iv. The SSA funds county, city, or tribal government to provide prevention services
 - v. The SSA funds community coalitions to provide prevention services.
15. Please list the specific primary prevention programs, practices, and strategies that are funded with SABG primary prevention dollars in each of the six prevention strategies.

Along with the information presented here, the list of evidence-based programs and practices (direct and environmental) are posted in a searchable database found on the Athena Forum website ([link to list](#)).

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

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

Problem Identification and Referral – SABG 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.

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

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

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

The following table displays the primary prevention programs, practices, and strategies funded with SABG primary prevention dollars in each of the six prevention categories.

CSAP Category	Program Name
Alternatives	Across Ages
Alternatives	Big Brothers Big Sisters Mentoring Program
Community-based Processes	Communities That Care (CTC)
Community-based Processes	Gathering of Native Americans
Community-based Processes	PROSPER
Education	Alcohol Literacy Challenge (ALC)
Education	All Stars
Education	Al's Pals: Kids Making Healthy Choices
Education	Athletes Training & Learning to Avoid Steroids
Education	ATLAS (Athletes Training and Learning to Avoid Steroids)
Education	Brief Alcohol Screening and Intervention for College Students (BASICS)
Education	Brief Strategic Family Therapy
Education	Child Development Project
Education	Children In Between
Education	Class Action
Education	Coping Power
Education	Coping with Work and Family Stress
Education	Creating Lasting Family Connections (CLFC)
Education	Curriculum Based Support Group Program (CBSG)
Education	DARE to Be You (DTBY)
Education	Early Risers--Skills for Success
Education	Familias Unidas
Education	Families and Schools Together (FAST)
Education	Family Effectiveness Training (FET)
Education	Family Matters
Education	Family Spirit
Education	Friendly PEERsuasion
Education	Good Behavior Game
Education	Guiding Good Choices
Education	Healer Women Fighting Disease Integrated Substance Abuse and HIV Prevention for African American Women (HWFD)

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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

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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

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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

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

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

Evaluation

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

Yes. The current State of Washington Substance Abuse and Mental Health Promotion Five-Year Strategic Plan was developed in 2012 and updated in 2015 ([link to plan](#)).

3. Does your state's prevention evaluation plan include the following components?
 - a. Washington's plan includes the following components:
 - i. Establishing methods for monitoring progress toward outcomes, such as targeted benchmarks – via the state Substance Use Prevention and Mental Health Promotion Online Management Information System (SUD Prevention and MH Promotion MIS).
 - ii. Includes evaluation information from sub-recipient – via the SUD Prevention and MH Promotion MIS.
 - iii. Includes SAMHSA National Outcome Measurement (NOMs) Requirements.
 - iv. Establishes a process for providing timely evaluation information to stakeholders.
 - v. Formalizes a process for incorporating evaluation findings into resource allocation and decision-making.

vi. Other:

1. Reports to sub-recipients
2. Evaluation of trainings offered by DBHR

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

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

- a. Washington collects the following measures:
 - i. Numbers served (for individual participants, aggregate counts, and population reach)
 - ii. Implementation fidelity
 - iii. Participant satisfaction
 - iv. Number of evidence-based programs/practices/policies implemented
 - v. Attendance
 - vi. Demographic information (age, race, ethnicity, income, language spoken, language ability, location, family military status)
- vii. Other:
 1. Service hours

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

- a. WA 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; Prescription; Heroin
- 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

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- f. Washington Healthy Youth Survey:
 - i. Underage Drinking (10th Grade)
 - ii. Marijuana Misuse/Abuse (10th Grade)
 - iii. Prescription Misuse/Abuse (10th Grade)
 - iv. Pain Killer User (10th Grade)
 - v. Tobacco Misuse/Abuse (10th Grade)
 - vi. E-Cigarette/Vapor Products Misuse/Abuse (10th Grade)
 - vii. Polysubstance Misuse/Abuse (10th Grade)
 - viii. Sad/Hopeless in Past 12 Months (10th Grade)
 - ix. Suicide Ideation (10th Grade)
 - x. Suicide Plan (10th Grade)
 - xi. Suicide Attempt (10th Grade)
 - xii. Bullied/Harassed/Intimidated (10th Grade)
 - xiii. Source of Alcohol, Pain Killers Used to Get High; Marijuana; Vapor Products(10th Grade)
 - xiv. Perception of Availability of Alcohol, Marijuana, Cigarettes; Opioids (10th Grade)
 - xv. Risk Perception of Alcohol, Marijuana (10th Grade)
 - 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

Section 11: Substance Abuse Treatment

PREGNANT AND PARENTING WOMEN (PPW)

Strategies for prioritizing pregnant women are contained within the contract language between the state of Washington, the BHOs, and the FIMC. The BHOs and FIMC must publicize the availability of treatment services to PPW at the facilities, as well as the fact that PPW receive priority admission.

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.

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- 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.

The BHO 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.
- Services specific to Post-Partum Women.
- Services may continue to be provided for up to one year postpartum.

The state also provides the agencies with a priority population poster and ask for it to be posted in the lobby of each agency.

INDEPENDENT PEER REVIEW

The state completes an annual independent peer review of its providers. The state requires the Behavioral Health Organizations 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 will be reviewed, the state expects to review the same number of providers in the upcoming year.

Section 12: QUALITY IMPROVEMENT PLAN

DBHR has a long-standing commitment to continuous quality improvement to ensure the best possible service delivery to its clients. DBHR's quality management program (QMP) provides a structure for system-wide quality improvement (QI) efforts and on-going evaluation of those efforts. Quality services are provided in a safe, effective, timely, equitable, and culturally competent manner. QI is the systematic use of data to improve client outcomes; to measure and assess the performance of

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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.

Section 17: RECOVERY SUPPORT SERVICES

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

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

Housing

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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 abuse 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.

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:

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- 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 teams with each team consisting of a Mental Health Profession and two certified peer counselors will provide supportive housing services to individuals exiting or at risk of entering inpatient behavioral health settings. In addition, \$1,500,000 in state funding is budgeted to provide housing 'bridge' subsidies for an estimated 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.

Oxford House

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. The average stay is approximately 12 to 24 months; there is no limit on length of stay. The Oxford House, based on the concept of promoting alcohol/drug recovery, are democratically run, self-supporting, and drug-free homes. Tenants pay their share of the rent and utilities, which averages \$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, as well as training on how to establish new chapters and how to keep the Oxford Houses a safe place of recovery.

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.

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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 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).

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

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- Increased housing stability in the community
- Improved client satisfaction with quality of life
- Decreased population-level disparities in access to treatment and treatment outcomes

In addition to measuring outcomes, the 2013 Washington State Legislature directed the Washington State Institute for Public Policy (WSIPP) to create, in consultation with the Department of Social and Health Services (DSHS), University of Washington Evidence-Based Practice Institute (EBPI), University of Washington Alcohol and Drug Abuse Institute (ADAI), and the Washington Institute for Mental Health Research and Training (WIMHRT), an inventory of evidence-based, research-based, and promising practices. Both PSH and SE are identified on the inventory, and as such, DBHR is working with national technical assistance organizations to increase awareness of the fidelity components of these two models. Maximizing the use of peers in these models has generated online continuing education curriculums to provide continuing education on PSH and SE. DBHR will also work with the Center for Continuing Education in Rehabilitation at the University of Washington to increase the skill level of employment specialists, housing specialists, and certified peer specialists. Increased awareness and fidelity to evidence-based practices (EBP), permanent supportive housing (PSH), and supported employment (SE) models will be achieved through webinars and in-person meetings on EBP, PSH, and SE models.

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

Section 22: STATE BEHAVIORAL HEALTH ADVISORY COUNCIL

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 persons 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 51 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.

DBHR serves BHAC as a policy partner with DBHR and BHAC has a role in the key decisions that affect quality and effectiveness of the programs and services DBHR oversees, including problem gambling.

The FFY2018-19 block grant was sent to council members to review prior to the July meeting.

Section 23: PUBLIC COMMENT ON THE STATE PLAN

Tribes

The Washington State Centennial Accord and Department of Social and Health Services Administrative Policy 7.01 ensure and maintain a commitment to Tribal Consultation in a formal Government-to-Government meeting to provide an opportunity for an exchange of information and opinion prior to a decision. In addition, the federal Medicaid rules require the state to meet and confer with Urban Indian Health Care Providers.

Roundtables and workgroups are used for discussions, problem resolution, and preparation or consultation. When matters are resolved by using the roundtable and workgroup processes, notification

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of any outcomes to these meetings are distributed to the affected administration, Office of Indian Policy, Tribes, Urban Indian Health Organizations, and RAIOS.

For the development of the block grant submission, the DBHR office sent the first letter to the tribal leadership on May 22, 2017, announcing a consultation meeting on July 14, 2017, between DSHS and tribal leaders of the 29 Federally Recognized tribes in Washington State. The natural conduit for ongoing communication is the HCA-BHA Monthly Tribal meeting. DBHR is committed to participation in these meetings to further develop and finalize the plan.

Stakeholders

On August 2, 2017, notices were provided via electronic format to stakeholders, DBHR staff, individuals with lived experience, and the general public regarding the opportunity to view and submit written comments on Washington State's block grant plan. Each comment was reviewed and incorporated as appropriate.

Priority Area #1	Reduce Underage and Young Adult Substance Use/Misuse
Priority Type	Substance misuse/abuse primary prevention
Population	<ul style="list-style-type: none"> • Children, youth, and adolescents (Age 0-17) • Young adults (Age 18-25) • Adults (parents, and older adults) • Populations with disproportionate SUD prevalence rates: <ul style="list-style-type: none"> • American Indian/Alaska Native • African-American • Hispanic • Multi-Race • Native Hawaiian • Other Pacific Islander
Goal of 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	<ul style="list-style-type: none"> • 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%). <p>Decrease the percentage of 10th graders who report misusing/abusing painkillers in the past 30 days (HYS 2016: 4.4%, Target 2023: 4.0%).</p>
Strategies to attain the objective	<ul style="list-style-type: none"> • Implement performance-based contracting with each prevention contractor. • Adapt programs to address the unique needs of each tribe. • Deliver 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 achievement of the objective	
Baseline measurement (initial data collected prior to and during SFY2018)	<p>SFY 2016 Service Numbers:</p> <ul style="list-style-type: none"> • 17,302 unduplicated direct services provided • Count of services delivered: <ul style="list-style-type: none"> ○ Environmental: 262 ○ Mentoring: 332 ○ Recurring: 3,996 ○ Single: 1,663 • 299 Programs by CSAP Category: <ul style="list-style-type: none"> ○ Alternatives: 37 ○ Community-based Process: 95 ○ Education: 110 ○ Environmental: 21 ○ Information Dissemination: 32 ○ Problem Identification and Referral: 4 • 77% of participants received Evidence-based Programs. • 34 total trainings offered to build workforce capacity, including 2 tribal-specific trainings. <p>1,381.5 hours of technical assistance provided to prevention contractors.</p>
First-year target/outcome measurement (progress to end of SFY2018)	<p>Maintain number of prevention programs and participants from SY 2016 baseline numbers:</p> <ul style="list-style-type: none"> • 17,302 unduplicated direct services provided • Count of services delivered: <ul style="list-style-type: none"> ○ Environmental: 262 ○ Mentoring: 332 ○ Recurring: 3,996 ○ Single: 1,663 • 299 Programs by CSAP Category: <ul style="list-style-type: none"> ○ Alternatives: 37 ○ Community-based Process: 95 ○ Education: 110 ○ Environmental: 21 ○ Information Dissemination: 32 ○ Problem Identification and Referral: 4 • 77% of participants received Evidence-based Programs.

	<ul style="list-style-type: none"> 34 total trainings offered to build workforce capacity, including 2 tribal-specific trainings. 1,381.5 hours of technical assistance provided to prevention contractors.
Second-year target/outcome measurement (Final to the end of SFY2019)	<p>Increase service capacity and maintain the number of prevention programs delivered to participants receiving services through:</p> <ul style="list-style-type: none"> Direct services provided (unduplicated participants). Count of services delivered (single, recurring, mentoring, and environmental). Count of programs delivered by CSAP Category. Percentage of participants receiving Evidence-based Programs. Number of trainings provided to build Workforce capacity. <p>Number of Technical Assistance hours provided to prevention contractors from DBHR</p>
Data source	<p>Washington's Management Information Service (SUD Prevention and MH Promotion Online Reporting System): used to report SABG performance indicators.</p> <p>Washington State Healthy Youth Survey (HYS): used to report 30 day use biannually.</p> <p>Washington State Young Adult Health Survey (YAHS): used to report young adult (Ages 18-25) substance use/misuse.</p>
Description of data	<p>SABG performance indicators are used to measure Center for Substance Abuse Prevention Strategies and Institute of Medicine Categories for services provided annually. From HYS, 10th grade Substance Use Among Washington Youth is used to measure intermediate outcomes.</p>
Data issues/caveats that affect outcome measures	<p>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 vendor to build system features specific to WA state as well as to define, test, and improve system enhancements.</p>

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Priority Area #2	Increase Youth Outpatient Substance Use Disorder Treatment
Priority Type	Substance use disorder treatment (SAT)
Population	<ul style="list-style-type: none"> • Youth who inject drugs • Youth who are pregnant or parenting • Low income youth • Populations who may be disproportionately impacted by SUD: <ul style="list-style-type: none"> ○ American Indian/Alaska Native ○ African American ○ Hispanic ○ Native Hawaiian ○ Other Pacific Islanders
Goal of priority area	Increase the treatment initiation and engagement rates among the number of youth accessing substance use disorder outpatient services.
Objective	<ul style="list-style-type: none"> • 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.
Annual Performance indicators to measure achievement of the objective:	
Baseline measurement (initial data collected prior to and during SFY2018)	<p>BHO service encounter data in CY 2016</p> <p>In Calendar Year 2016, 3,588 youth received SUD outpatient treatment.</p>
First-year target/outcome measurement (progress to end of SFY2018)	DBHR increase the number of youth served from 3,588 to 3,688.
Second-year target/outcome measurement (Final to the end of SFY2019)	DBHR increase the number of youth served from 3,688 to 3,788.
Data source	BHA Behavioral Health Data System (BHDS)
Description of data	"CY 2016 Served" is an unduplicated count of youth (persons under 18 years of age) served in publically-funded SUD outpatient treatment between January 1, 2016, and December 31, 2016.
Data issues/caveats that affective outcome measures	DBHR combined behavioral health services coverage which has caused data reporting challenges because of the way data was collected in the past changed. Indian Health Care

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	Providers have to enter data into multiple systems which is burdensome.
Priority Area #3	Increase mental health outpatient services to adults with SMI
Priority Type	Mental Health Services (MHS)
Population	<ul style="list-style-type: none"> Adults with Serious Mental Illness (SMI) Populations that maybe disproportionately impacted with SMI: <ul style="list-style-type: none"> American Indian/Alaska Native African American Hispanic Native Hawaiian Other Pacific Islanders
Goal of priority area	Increase the number of adults with SMI accessing mental health outpatient services.
Objective	<ul style="list-style-type: none"> Require BHOs to maintain and enhance behavioral health provider network adequacy. Increase available mental health behavioral health services for adults.
Strategies to attain the objective	Convene Medicaid enrollment workgroup to determine best practices for enrollment at point of first contact. Gather data and resources regarding how potential consumers are identified.
Annual Performance indicators to measure achievement of the objective:	
Baseline measurement (initial data collected prior to and during SFY2018)	<p>BHO service encounter data in CY 2016</p> <p>In Calendar Year 2016, approximately 124,887 adults received mental health outpatient services</p>
First-year target/outcome measurement (progress to end of SFY2018)	Increase the number of adults with SMI served from 124,887 in calendar year 2016 to 125,347.
Second-year target/outcome measurement (Final to the end of SFY2019)	Increase the number of adults with SMI served from 125,347 to 125,807.
Data source	BHA Behavioral Health Data System (BHDS)
Description of data	"CY 2016 Served" is an unduplicated count of adults (persons 18 years of age and older) served in publically-funded mental health outpatient programs between January 1, 2016 and December 31, 2016
Data issues/caveats that affective outcome measures	DBHR combined behavioral health services coverage which has caused data reporting challenges because the way in which data was collected in the past changed. Indian Health

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Priority Area #4	Increase outpatient substance use disorder treatment for adults
Priority Type	Substance Use Disorder Treatment (SAT)
Population	<ul style="list-style-type: none"> • Pregnant women and women with dependent children (PWWDC) • Adults who inject drugs (PWID) • Populations that may be disproportionately impacted with SUD: <ul style="list-style-type: none"> ○ American Indian/Alaska Native ○ African-American ○ Hispanic ○ Native Hawaiian ○ Other Pacific Islanders
Goal of 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 indicators to measure achievement of the objective	
Baseline measurement (initial data collected prior to and during SFY2018)	<p>BHO service encounter data in CY 2016</p> <p>In Calendar Year 2016, 34,899 adults received SUD outpatient treatment.</p>
First-year target/outcome measurement (progress to end of SFY2018)	The number of adults receiving SUD outpatient services will increase from 34,899 in Calendar Year 2016 to 35,912 in Calendar Year 2017.
Second –year target/outcome measurement (Final to the end of SFY2019)	The number of adults receiving SUD outpatient services will increase from 35,912 in Calendar Year 2017 to 36,925 in Calendar Year 2017.
Data source	BHA Behavioral Health Data System (BHDS)
Description of data	“CY 2016 Served” 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 affective 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

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<p>Priority Area: #5</p> <p>Maintain Government to Government relationships with Tribal Governments</p> <p><i>Government-to-Government</i> describes the relationships and protocols among and between Federally Recognized Tribes and the federal, state and other governments (DSHS Administrative Policy 7.01, page 2).</p>
<p>Priority Type</p> <p>The Department of Social and Health Services (DSHS) and the Health Care Authority (HCA) follow a government-to-government approach to seek consultation and participation by representatives of tribal governments in policy development and service program activities. This is in compliance with Chapter 43.376 RCW, the Washington State 1989 Centennial Accord and current federal Indian policy as outlined by Executive Order #13175, and the Presidential Memorandum on Tribal Consultation signed by President Obama in November 2009, which promotes government-to-government relationships with American Indian Tribes (DSHS Administrative Policy 7.01, page 1).</p>
<p>Population</p> <p>American Indian/Alaska Natives</p>
<p>Goal of priority area</p> <p>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.</p>
<p>Objectives</p> <ul style="list-style-type: none"> • 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.
<p>Strategies to attain the objective</p>

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<ul style="list-style-type: none"> • 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 achievement of the objective
a) Baseline measurement (initial data collected prior to and during SFY2018) the total number of SUD prevention programs in SFY2016 funded with SABG funds was 45, the number of unduplicated participants in SFY2016 funded with SABG was 471. The total number of clients who received treatment services funded with SABG funds in SFY2016 was 532.
b) First-year target/outcome measurement (progress to end of SFY2018) Maintain the number of prevention programs in SFY2018 as there were in SFY2016. Maintain the total number of clients who received treatment services in SFY2018 as there were in SFY2016.
c) Second-year target/outcome measurement (Final to the end of SFY2019) Maintain the number of prevention programs in SFY2019 as there were in SFY2016. Maintain the total number of clients who received treatment services in SFY2019 as there were in SFY2016.
d) Data sources: Substance Use Disorder Prevention and Mental Health Promotion on-line reporting system and TARGET.
e) Description of data: The number of unduplicated participants in SUD prevention and the total number of clients who received treatment services in SFY2016.
f) Data issues/caveats that affective outcome measures

Priority Area #6	Provide recovery support services, including housing and employment services for individuals with SMI, SED, and SUD
Priority Type	Mental Health Services (MHS) Substance Use Disorder Treatment (SAT)
Population	Adults with Serious Mental Illness (SMI) Children with an Serious Emotional Disorder (SED) Pregnant women and women with dependent children (PWWDC) Persons who inject drugs (PWID) Other individuals needing recovery support services
Goal of priority area	<p>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):</p> <ul style="list-style-type: none"> • 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 <p>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.</p>
Objective	<ul style="list-style-type: none"> • Decrease homelessness for adults with behavioral health issues by 10% • Increase the employment rate for adults with behavioral health issues by 10% • 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	<ul style="list-style-type: none"> • 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

	<ul style="list-style-type: none"> Assist 25 behavioral health agencies implement evidence-based practices permanent supportive housing and supported employment models
Annual Performance indicators to measure achievement of the objective	
Baseline measurement (initial data collected prior to and during SFY2018)	<ul style="list-style-type: none"> Number and percent of individuals with any identified homelessness or housing instability in any of five data systems Number and percentage of individuals with any earnings in the quarter of service
First-year target/outcome measurement (progress to end of SFY2018)	<ul style="list-style-type: none"> Increased awareness and fidelity to evidence-based practices (EBP) permanent supportive housing (PSH) and supported employment (SE) models by training 500 staff through webinars and in-person meetings on EBP, PSH, and SE 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
Second-year target/outcome measurement (Final to the end of SFY2019)	<ul style="list-style-type: none"> Increased awareness and fidelity to evidence-based practices (EBP) permanent supportive housing (PSH) and supported employment (SE) models by training 500 staff through webinars and in-person meetings on EBP, PSH, and SE Assist 300 individuals exiting or at risk of entering inpatient behavioral health settings with housing supports Assist 300 individuals to obtain employment Assist 10 behavioral health agencies implement evidence-based practices permanent supportive housing and supported employment models
Data source	ACES (DSHS Medicaid Eligibility System), Homeless Management Information System (HMIS) and the Behavioral Health Data Systems
Description of data	<p>Number and percent of individuals with any identified homelessness or housing instability in any of five data systems</p> <p>Number and percentage of individuals with any earnings in the quarter of service</p>
Data issues/caveats that affective outcome measures	<p>The 5732-1519 workgroup sought to align housing measures with homelessness measures used by other systems such as the U.S. Department of Housing and Urban Development (HUD), the Washington State Department of Commerce, and local housing providers. Three separate populations sought for measurement included individuals living in places not meant for habitation (such as the street, tents, or cars), individuals homeless but sheltered (such as in emergency shelters), and individuals at risk of homelessness (such as those staying temporarily with friends or family members). Special focus was paid to the need to identify housing and residential measures appropriate for long-term care clients. After much discussion and additional analyses of proposed measures, this was accomplished through a measure included in the</p>

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	workgroup’s recommended measures: for Home and Community-based Long Term Care services and supports use, the proportion of person-months receiving long-term services and supports associated with receipt of services in home- and community-based settings during the measurement year. Additionally, as the housing measures go forward, the state must guard against the use of institutions (nursing facilities, state psychiatric hospitals) as a method to reduce housing instability.
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Priority Area #7	Develop a peer support program for individuals with substance use disorders (SUD)
Priority Type	Substance use disorder treatment (SAT)
Population	Individuals with substance use disorders Persons who inject drugs (PWID)
Goal of 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	<ul style="list-style-type: none"> • Pilot SUD peers • Develop a strategic to review curriculum, funding strategies and rule changes
Strategies to attain the objective	<ul style="list-style-type: none"> • 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 achievement of the objective	Number of SUD peers providing services through pilot projects
Baseline measurement (initial data collected prior to and during SFY2018)	Twenty SUD peers are providing services through the Peer Pathfinder project as indicated in monthly reports.
First-year target/outcome measurement (progress to end of SFY2018)	Twenty SUD peers are providing services through the Peer Pathfinder project as indicated in monthly reports.
Second-year target/outcome measurement (Final to the end of SFY2019)	Twenty eight SUD peers are providing services through the Peer Pathfinder project as indicated in monthly reports
Data source	Monthly reports submitted to DBHR through the STR Peer Pathfinder project
Description of data	Excel reports indicating the number of individuals served by SUD Peers on the Pathfinder project
Data issues/caveats that affective outcome measures	

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Priority Area #8	Increase outpatient mental health services to youth
Priority Type	Mental Health Services (MHS)
Population	Children diagnosed with serious emotional disorder (SED)
Goal of 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	<ul style="list-style-type: none"> • Require BHOs to maintain behavioral health provider network adequacy. • Increase available MH community based behavioral health services for youth diagnosed with SED.
Annual Performance indicators to measure achievement of the objective	
Baseline measurement (initial data collected prior to and during SFY2018)	<p>BHO service encounter data in CY2016</p> <p>In calendar year 2016, - 50,451 youth received outpatient mental health services</p>
First-year target/outcome measurement (progress to end of SFY2018)	Increase the number of youth diagnosed with SED receiving mental health outpatient treatment from 50,451 to 51,000.
Second –year target/outcome measurement (Final to the end of SFY2019)	Increase the number of youth diagnosed with SED receiving mental health outpatient treatment from 51,000 to 51,450.
Data source	NHA Behavioral Health Data System (BHDS)
Description of data	Calendar year 2016 is an unduplicated count of adults (persons under the age 18) served in publically-funded outpatient mental health programs from January 1, 2016 through December 31, 2016.
Data issues/caveats that affective outcome measures	