ORGANIZATION OF THE BEHAVIORAL HEALTH SYSTEM

The Department of Social and Health Services (DSHS) is Washington's largest state agency and houses the majority of the Washington state's social and behavioral health programs. In any given month, DSHS provides some type of shelter, care, protection, and/or support to 2.2 million of our state's 6.8 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 collaborates with the State Medicaid Authority (the Health Care Authority-HCA) through formal Memoranda of Understanding (MOU) for behavioral health services. Prevention and promotion activities are through interagency agreements with the Office of Superintendent of Public Instruction (OSPI) for Community Prevention Wellness Initiatives, the Liquor Cannabis Board (LCB) for Alcohol and Marijuana Initiative, and the Department of Health (DOH) for Suicide, Tobacco and Marijuana Prevention.

DSHS is divided into six direct service administrations including the Behavioral Health and Service Integration Administration (BHSIA). All administrations are committed to the single mission: Transforming Lives. DSHS will improve the safety and health of individuals, families, and communities by providing leadership in establishing and participating in partnerships. Together we will decrease poverty, improve the safety and health status of citizens, increase educational and employment success, and support people and communities in reaching their potential.

BHSIA includes the Division of Behavioral Health and Recovery (DBHR) and the state hospitals. BHSIA's core services focus on:

- Individual Support – Providing support to clients who face challenges related to mental illness or addiction, including the prevention of substance abuse and gambling addiction.
- Health Care Quality and Costs – Designing and implementing integrated care systems in conjunction with other DSHS administrations and HCA 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 BHSIA, Developmental Disabilities Administration and Aging and Long Term Support Administration.

BHSIA operates three state psychiatric hospitals. Eastern State Hospital and Western State Hospital deliver high-quality inpatient psychiatric care to adults who have been committed through the civil or criminal court system for treatment and/or competency restoration services. The Child Study and Treatment Center provides high-quality inpatient psychiatric care and education to children ages 5 to 17 who cannot be served in less restrictive settings in the community due to their complex needs.

The three state hospitals have a combined inpatient capacity to serve 1,100 patients. In addition to providing inpatient services, the hospitals also provide outpatient forensic services for individuals who are awaiting an evaluation or for whom the courts have ordered an out of custody competency evaluation.

DBHR provides support for Mental Health, Substance Use Disorder, and Problem Gambling Services. Chris Imhoff is the director of the Division of Behavioral Health and Recovery and, as such, serves as the director for SSA and SMHA.

The majority of public behavioral health services in Washington State supported by state or federal funds are managed by DBHR, including program policy and planning, program implementation and oversight, provider certification, fiscal and contract management, Management Information Systems (MIS), and comprehensive program outcome studies.

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

Over the last biennium (July 1, 2013 - June 30, 2015):

- 208,240 clients participated in mental health treatment provided through 11 Regional Support Networks (RSNs).
- 71,272 clients participated in substance abuse treatment.
- 34,603 clients received direct services with community strategies reaching 146,218 clients with substance abuse prevention activities.
- 819 clients participated in gambling treatment.

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

- Building on a continuum of services, from prevention programs to early identification and intervention projects that use behavioral health treatment and

recovery oriented services, while incorporating evidence-based programs and practices whenever possible.
- Redesigning the children's mental health system to expand wraparound services throughout the state.
- Developing an innovative program to address transition age youth who have experienced a first episode psychosis.

The Unified Block Grant will be an important driver to assist Washington State and DBHR to move toward an integrated Behavioral Health System of Care. DBHR will use Block Grant funds to initiate the plan for change. We will continue to address existing Block Grant requirements while working to improve the Affordable Care Act. Specifically, our plan will address SAMHSA-required areas of focus, including:

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

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

- Children, youth, adolescents, and youth-in-transition with or at risk for substance abuse and/or mental health problems.
- Those with a substance use and/or mental health problem who are:
    - Homeless or inappropriately housed.
    - Involved with the criminal justice system.
    - Living in rural or frontier areas of the state.
    - Military service members, veterans, or military family members.
- Members of traditionally underserved populations, including:
    - Racial/ethnic minorities.
    - LGBTQ populations.
    - Persons with disabilities.

As we assess the Washington state behavioral health service system, it is clear the complexity of the system defies a simple description. In the next few sections, the system will be described from several lenses:
- The contracting of the state's public behavioral health system with a particular focus on how the system is currently organized around children/youth and adult services and how it will look in April 2016 as we transition to managed care.
- An overview of the continuum of care offered by Washington State.
- The strengths and needs of behavioral health service providers.

- A description of how our system addresses the needs of under-served populations.

We will also describe specific needs for behavioral health in the state. Throughout our narrative, we incorporate the voices of consumers, tribes, and other system partners.

CONTRACTING OF THE PUBLIC BEHAVIORAL HEALTH SYSTEM

Mental Health Contracting

Regional Support Networks

In 1989, the Washington State Legislature enacted the Community Mental Health Reform Act, which consolidated responsibility and accountability for community mental health treatment and care through Regional Support Networks (RSNs) to carry out state legislative mandates. RSNs are Prepaid-Inpatient Health Plans and carry out federal Medicaid requirements.

Regional Support Networks (RSNs) are the administrators of public mental health services in Washington State, and provide mental health services through contracted providers in their regions. There are currently 11 RSNs: Chelan-Douglas, Grays Harbor, Greater Columbia, King County, North Sound, Optum Pierce, Peninsula, Southwest, Spokane, Thurston/Mason, and Timberlands. Each of the RSNs subcontract for mental health services with counties within their catchment area.

RSNs receive Medicaid funding based on a per-member-per-month formula for adults and children within their regions. State-only and block grant funding is allocated to RSNs based on their total population.

The RSNs are required to prioritize state funds for crisis services and involuntary treatment act services. Consumers obtain services, both Medicaid and non-Medicaid, through one of 11 RSNs and their network of over 150 community-based mental health providers. The Health Care Authority (HCA), as the state Medicaid authority, funds tribal Medicaid services at the federal encounter rate and has extended this option to include “clinical family members” who are also Medicaid consumers. DBHR works with the HCA to provide technical assistance and training to tribal mental health providers. RSNs operate an involuntary treatment system for persons over the age of 12 who are found to be gravely disabled or dangerous to themselves or to others. Services for Medicaid enrollees are provided through a 1915(b) Medicaid waiver. Services for some non-Medicaid enrollees are funded with state dollars and Mental Health Block Grant funds.

The block grant supports critical services such as: homeless services, housing assistance; crisis outreach; consumer-operated programs such as mental health clubhouse services; and education, training, and support for consumers and their

families that are not covered by Medicaid or state direct funds.

Because the community mental health system is funded under a capitation arrangement with county-based RSNs receiving a monthly payment intended to cover the cost of providing mental health services in the catchment area, RSNs are directed to accomplish all of the requirements in the contract with the overall funding they receive.

Tribal Programs
Contracts, with state funds, are held directly with tribal mental health programs for the purpose of mental health promotion through culturally specific activities; sweats and canoe journeys.

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

Substance Use Disorder Contracting
State-certified outpatient treatment services, including Opiate Substitution (OST), Pregnant and Parenting Women (PPW) Housing Support, and Withdrawal Management (previously known as Detoxification) - acute and sub-acute - for youth and adults are managed through contracts offered to each of the 39 counties (some counties jointly manage these funds). This allows for the identification of local needs and leveraging of local funds to support behavioral health services in each community. Contracts incorporate block grant requirements; including priority populations, wait list and interim services, tuberculosis services, and continuing education. All block grant requirements are passed down to each of the subcontractors.

Tribes
Substance Abuse Block Grant funds are allocated to tribal substance use disorder programs of each of the 29 federally recognized tribes in Washington State to support the delivery of culturally-based treatment services and prevention activities. As decided through a Tribal Consultation process, funds are distributed to tribes using a 30/70 formula. The formula allocates 30 percent of the dollars evenly among all tribes and 70 percent is distributed on a per capita basis determined by the most current Indian Health Services' service area population figures. Tribal programs provide services mostly to the tribal populations, but at the discretion of the tribe can serve nontribal members as well.

Direct Contracting
DBHR contracts directly with state-certified substance use disorder residential treatment programs for youth, adult, and pregnant and parenting women. Contracts include

specific assessment and counseling requirements, staffing ratios, reporting and referral requirements, and any appropriate block grant requirements. Treatment for family and significant others is included, as well as relapse and long-term recovery education and counseling.

Managed Care

In 2014, the legislature enacted SB 6312, which set the course for care integration in Washington State. Under this new law, Behavioral Health Organizations (BHOs) will become the single, regional entities with responsibility and financial risk for providing substance use disorder treatment and all of the mental health services currently managed by the RSNs. These include inpatient and outpatient treatment, involuntary treatment and crisis services, jail proviso services, and services funded by the federal block grant.

DSHS will begin the contracting process in 2015 for services starting in April 2016. On July 1, 2015, DSHS released a "Request for Detailed Plan" as the first step in qualifying regional organizations to become BHOs.

Involuntary Treatment

The state contracts with secure, long-term residential programs to provide treatment for individuals who have substance use disorder and are a danger to themselves or others. DBHR expects every county to designate a County Designated Chemical Dependency Specialist (CDCDS) to coordinate the legal and referral process to one of two residential facilities: Pioneer Center North in Sedro Woolley or Pioneer Center East in Spokane.

Prevention

DBHR prioritizes funding for scientifically-proven strategies to reduce substance abuse, while at the same time recognizing the importance of local innovation to develop programs for specific populations or emerging problems.

Funding is primarily disseminated via:

- County client service contracts
- Interlocal contracts
- Consolidated Intergovernmental Agreements (IGA) with Washington State Federally Recognized tribes through the Office of Indian Policy (OIP)
- Personal service agreements made for services such as training for workforce development and capacity building

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

Washington State's Community Prevention and Wellness Initiative (CPWI) is a strategic,

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

DBHR contracts with the Office of the Superintendent of Public Instruction (OSPI) for the placement of prevention/intervention specialists in schools to provide universal, selective, and indicated prevention and intervention services. Prevention/intervention specialists assist students to overcome problems of substance abuse and strive to prevent the abuse of, and addiction to, alcohol and other drugs, including nicotine. These prevention/intervention specialists also make referrals to mental health and substance use disorder treatment providers and support students in their transition back to school after they receive treatment.

ADULT BEHAVIORAL HEALTH SYSTEM

Substance use disorder treatment

DBHR provides a full array of treatment services. Levels of services are based on results from an assessment followed with treatment plans that are individualized and designed to maximize the probability of recovery.

Access to substance use disorder outpatient treatment services is initiated through an assessment at a local outpatient or residential facility. The American Society of Addiction Medicine Patient Placement Criteria (ASAM-PPC) level of care determination is based on the initial assessment and directs medically necessary services as well as determines where the services should be provided.

There are a number of ways a person can receive treatment services. Most people will find that treatment services are part of their health insurance package purchased when they go through the HealthPlanFinder – even and especially those that are "newly eligible". A client may be referred, who doesn't appear to have health coverage, to the HealthPlanFinder but especially if they need services.

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

Withdrawal management services assist patients' withdrawal from alcohol and other drugs. Acute withdrawal management occurs in a medical setting and provides medical care. Sub-acute withdrawal management occurs in a home-like environment in which

patients may self-administer medications ordered by a physician for use while the patient is in the facility.

There are currently three types of residential substance use disorder (SUD) treatment for adults in the state. Intensive inpatient treatment provides a concentrated program, of individual and group counseling, education, and activities for people who are addicted to substances and their families. There are currently 20 adult intensive inpatient providers with a capacity of 552 slots statewide. Each patient participating in this level of substance use disorder treatment receives a minimum of 20 hours of treatment services each week. Long-term treatment provides treatment for the chronically impaired adult with impaired self-maintenance capabilities. There are currently seven adult long-term residential providers with a total capacity of 135 slots. Each patient participating in this level of substance use disorder treatment receives a minimum of four hours of treatment per week. Recovery Houses provide personal care and treatment, with social, vocational, and recreational activities to aid with patient adjustment to abstinence, as well as with 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.

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

Recovery Housing Support Services are provided to women who have completed primary treatment to maintain recovery and learn the skills they need to be nurturing parents and become financially self-sufficient. Services for women in a safe, clean and sober house include 24 hour non-clinical staff to provide a safe secure environment, transportation to other health care appointments, and child care staff.

Medication-Assisted Treatment (MAT) is pharmacotherapy for substance abuse. It combines pharmacological intervention with counseling and behavioral therapies. This is also known as Opiate Substitution Treatment (OST). These treatment programs must address an array of comprehensive medical, vocational, employment, legal, and psychological issues or provide referrals to community based programs that have the expertise to address these issues. Currently, there are 16 sites offering public-funded services including two tribal programs.

DBHR recognizes the following MAT medications for the treatment of addictions: Methadone; Buprenorphine (Suboxone); Acamprosate (Campral); and Naltrexone

(Vivitrol or ReVia). These medications must be prescribed by a physician. Medicaid payment authorization is also required for utilization of this type of treatment.

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

DBHR is responsible for planning, implementing, and overseeing the Pathological and Problem Gambling Treatment program. The problem gambling program is funded through a state tax on gaming. This program includes an advisory committee that oversees prevention and treatment services. Services include educating the public on how to identify problem and pathological gambling, and how to obtain outpatient treatment services for problem and pathological gamblers and 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 also less likely to need financial assistance from other state programs.

Mental Health

Voluntary and involuntary community inpatient services for adults are authorized by the Regional Support Networks (RSNs) and are provided in community hospital psychiatric units and in freestanding non-hospital evaluation and treatment facilities (E&Ts). Some of these inpatient resources are certified to provide short-term (up to 17 days) Involuntary Treatment Act services.

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

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

Approximately 70% of individuals at the state hospitals are under civil commitment orders. The remaining 30% receive court-ordered forensic services. These include:

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

CHILDREN AND YOUTH BEHAVIORAL HEALTH SYSTEM

Substance use disorder prevention

Based on many years of experience funding community-level prevention, DBHR began the Prevention Redesign Initiative (PRI) with the goal of supporting population level change in the state's highest risk communities. Following from experience with the Strategic Prevention Framework (SPF) State Incentive Grant (SIG), the PRI has used survey and archival data to identify those high-risk communities, and developed extensive guidelines for implementing a coalition-run SPF process in each, supported by a Prevention-Intervention Specialist in either the middle or high school, and a state level logic model.

The PRI title was change to a name that more clearly defined the Washington state prevention system as a strategic, data-informed, community coalition model aimed at bringing together key local stakeholders to provide the needed infrastructure and support to successfully coordinate, assess, plan, implement and evaluate youth substance use prevention services needed in their community. The new name is Washington State's Community Prevention and Wellness Initiative (CPWI).

Substance use disorder treatment

Access to substance use disorder treatment services for youth is initiated through an assessment at a local outpatient or residential facility. The American Society of Addiction Medicine (ASAM) level of care determination is based on the initial assessment and directs where and what services are provided. The age of consent for outpatient substance use disorder services is 13 years old and older. Youth may independently seek treatment services. Alternately, a parent may bring a youth to a certified treatment agency for an assessment to determine if there is medical necessity for outpatient treatment (RCW 70.96A.250). The consent of the minor for this assessment is not required; however, consent is required for treatment services.

State certified outpatient programs generally provide substance use disorder assessments and alcohol-/drug-free counseling for adolescents ages 10 through 17 (but

young adults ages 18-20 or children under 10 may be served in youth agencies if developmentally appropriate, with approval of a DBHR manager). Collateral and family support services may also be provided to family members of youth. Outpatient treatment programs are designed to diagnose, stabilize, counsel, and build family and social support systems to promote personal development and recovery.

Depending upon the level of care needed, individual programs may provide more intensive interventions and services. Youth Residential substance use disorder services are composed of four modalities, including Withdrawal Management and Crisis Stabilization services.

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

Youth appropriate for Recovery House services have completed residential substance use disorder treatment, and are transferred to a Recovery House when they cannot immediately live with their legal guardians, parents, foster parents, other relatives, or at another out-of-home placement. Recovery House Programs provide structure and supervision, continued treatment with an emphasis on recovery and abstinence, and improvement of living skills, including education and employment skills. The programs also provide access to community support systems, and youth participation in age-appropriate activities. Length of stay can be up to120 days.

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

Mental Health

RSNs, through contracts with community mental health agencies, provide a complete array of services to children and youth with serious emotional disorders (SEDs) who meet the Access to Care standard (diagnosis and level of functional impairment) and standardized medical necessity criteria. The list of possible services may include brief

intervention, crisis services, family treatment, freestanding evaluation and treatment, individual and group treatment, high intensity treatment, medication management and monitoring, residential treatment, and stabilization services.

Based on a Settlement Agreement entered into following a class action lawsuit, Washington state has embarked on a process to improve access to, and effectiveness of, intensive individualized behavioral health services delivered in home or community for youth affected by serious emotional disturbances. Wraparound with Intensive Services (WISe) is being progressively implemented throughout the state with full implementation to be completed by 2018.

In July 2014, Washington state's community mental health system began rolling out a new program model that will be available in every county across the state by June 2018. This new model, Wraparound with Intensive Services (commonly called WISe) is designed to meet the complex behavioral health needs of children and youth on Medicaid up to 21 years of age. The goal of WISe is to provide services that allow youth to live and thrive in their homes and communities, while avoiding or reducing costly and disruptive out-of-home placements.

WISe is different from traditional mental health services in a number of ways:

- The intensity of services available within the community: WISe is set up to keep youth with intense mental health needs safe in their own communities and receiving a level of services that meets their individual needs. This higher level of services within communities is not currently available in every county across state, and at times youth had to go into inpatient treatment settings to get the level of care they needed, instead of being able to get the help they needed while staying in their homes.

- The time and location of services: WISe services are not office-based. They take place in locations that work best for the youth and family, at times that work best for the family (including at their house on evenings and weekends).

- Team-based approach: WISe relies on the strengths of an entire team, working together to meet the needs identified by the youth and family. WISe uses a wraparound model in which teams are made up of both natural supports and individuals from the child-serving system partners that the youth and family may have in their lives at the time. Some examples of these partners might be school personnel, a probation officer, a religious leader, a chemical dependency counselor, or a coach/teacher of an extracurricular activity. Youth partners and/or family partners are also a part of every team to ensure youth and family voice and choice is heard. The team, driven by youth and family choice, creates ONE cross-system Care Plan that includes strategies and supports to overcome the challenges met by the youth and his or her family, while building upon the family's resiliency. This intensive care coordination between all partners is critical in meeting the needs of the youth's well-being in its entirety.

- Help from someone they know when in crisis: As part of each individualized crisis plan, youth and families have access to crisis services any time of the day, 365 days a year. These services are provided by an individual that is known to the youth and family, and is familiar with that family's crisis plan. Whenever necessary, this includes face-to-face interventions, where the individual goes out to the location where the crisis in occurring.

There are two freestanding Evaluation and Treatment Centers in Kitsap and Yakima counties providing involuntary treatment services for youth. In addition, 3 community hospitals provide acute psychiatric care for youth. Longer term inpatient mental health services for children and youth, both voluntary and involuntary, are provided through the centralized Children's Long-Term Inpatient Program (CLIP). The CLIP facilities include the Child Study and Treatment Center, a 47-bed state-run psychiatric hospital, as well as an additional 37 beds at three non-hospital based inpatient residential facilities. Written agreements between CLIP and each RSN detail the responsibilities for the resource management of these 84 beds. Children and youth under 21 who do not meet the Access to Care standards have a mental health benefit available under the Health Care Authority (HCA) fee-for-service (FFS) or managed care systems. Under these systems, a child/youth can receive sessions of mental health treatment as medically indicated.

Through community presentations, clinical trainings, fact sheets, and publications, we will increase awareness of schizophrenia and psychosis, reduce the stigma associated with schizophrenia and psychosis, encourage people to get the facts about symptoms, and increase early identification and referrals for young people experiencing a first episode of psychosis.

DBHR is partnering with Early Assessment and Support Alliance (EASA) to create positive outcomes for Transition Age Youth (15-25) experiencing a First Episode of Psychosis (FEP). EASA is a systematic effort that originated in Oregon to prevent early trauma and disability caused by schizophrenia-related conditions. Washington is currently partnering with EASA and Central Washington Comprehensive Mental Health to implement a First Episode Pilot Program (New Journeys) in Yakima County

Workforce Development

DBHR is committed to improving the skills of DBHR staff, providers, consumers, and members of the Behavioral Health Advisory Council in an effort to ensure public behavioral health services are culturally-competent and effective.

DBHR supports these six statewide conferences and trainings each year:

1. Co-Occurring Disorders and Treatment Conference
2. Prevention Summit
3. Spring Youth Forum
4. Saying It Out Loud Conference
5. Behavioral Health Conference

6. Summer Coalition Leadership Institute

Additional trainings provided through contracts with the Office of the Superintendent of Public Instruction, counties, and RSNs are well attended and receive high ratings for quality.

DBHR also works in collaboration with Northwest Addiction Technology Transfer Center (NWATTC) to offer workforce trainings. Priority topic areas have trainings offered in Western Washington and Eastern Washington to provide availability statewide. Topic areas which will be offered prior to the end of this grant year (2015) are as follows: Introduction to Motivational Interviewing, Clinical Skills in the Era of Legal Cannabis, Behavioral Health Organization (BHO) ASAM training (single training), Co-Occurring Disorders Treatment for Youth, Co-Occurring Treatment for Adults, and Treatment Planning - Measurable, Attainable, Time-Limited, Realistic and Specific, referred to as Treatment Planning (MATRS).

The Co-Occurring Disorders (COD) and Treatment Conference provides consumer and family attendees with information regarding current legislation related to mental health care/services, current resources, and treatment methodologies. The conference also provides opportunities for participants to network with other families and individuals with COD.

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

The Saying it Out Loud Conference is planned in partnership with the Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) community and several divisions or offices within the department (e.g., DBHR, Children's Administration, Division of Vocational Rehabilitation, Development Disabilities Administration, Rehabilitation Administration, and 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

in the LGBTQ community, as well as current resources and research. DSHS has a long-standing record of supporting and partnering with the LGBTQ community.

Each year the latest research and best practices for how families, faith communities, schools, and behavioral health providers can promote lifelong health and wellbeing for LGBTQ youth is shared with conference attendees. In the past, advocates for youth focused primarily on preventing harassment and bullying or mitigating the trauma of family and societal rejection.

County contracts include a requirement that providers and their staff be provided opportunities to receive additional trainings in their field of study. Counties, based on the changing demographics and needs of clients, support trainings such as:

- The Matrix Model
- Moral Resonation Therapy (MRT)
- Global Appraisal of Individual Needs (GAIN)
- Mental Health First Aid
- Crisis Response
- Enhancing Supervision Skills
- Prevention Pathways
- Substance Abuse Prevention Skills Training
- Ethics/Confidentiality
- Cultural Diversity
- Medication Management
- Motivational Interviewing
- Crisis Intervention

The Behavioral Health Conference is a two-day statewide behavioral healthcare conference presented by the Washington Community Mental Health Council (WCMHC) and supported by the Federal Block grant funding administered through DBHR. This year's conference, "Fulfilling the Promise of Integrated Care," was held June 17-19, 2015, in Vancouver.

The conference audience include mental health professionals in areas of aging, developmental disabilities, children's services, substance use disorder and other specialties, consumers and consumer advocates, administrators, staff of public and nonprofit agencies and other stakeholders. This year's funding was increased to support the coordination of registration scholarships for up to 200 consumers/consumer advocates, 70 DBHR staff, and 16 Behavioral Health Advisory Committee (BHAC) members to attend the event.

The Summer Coalition Leadership Institute is an annual three-day training event to advance the prevention workforce with knowledge and skills. The audience is primarily community coalition coordinators, coalition leadership, Educational Service District partners, and state agency Prevention Policy Consortium Members. Topics this year included understanding academic impacts related to adolescent and young adult

substance use. These sessions offered knowledge building to interpret the trend data, ways to develop partnerships, and effective prevention strategies. The participants also received one full-day of training on reducing Health Disparities in Washington State. Other sessions included training on basic facilitation skills and group conflict resolution. This training event is an opportunity to highlight other programs having success in the CPWI communities and for the coordinators to network and share successes and challenges to learn from each other. This training is offered at no cost and is written into our Partnerships for Success application and it is also supported with the SABG funding. This year 14 of the 17 hours were acknowledged by the Prevention Specialist Certification Board of Washington for Continuing Education Hours that prevention professionals can use to support their credential.

In addition, RSNs provide the following trainings to consumers:

- Peer-to-Peer
- Mental Health First Aid
- Peer Certification
- Wellness Recovery Action Plan

Strengths and Needs of Washington State's Behavioral Health System

DBHR includes services and program support for behavioral health, prevention, early intervention, treatment and recovery support services for individuals with substance use disorder, serious mental illness, serious emotional disturbance, and/or dual diagnoses. The co-location of mental health and substance use disorder within a single division has been a significant strength in Washington state as we move forward in implementing health care reform. Washington recognizes the importance of prevention, early intervention, and the need for ready access to services.

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

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

AN OVERVIEW OF THE CONTINUUM OF CARE

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

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

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

Through a number of programs, DBHR supports the prevention of mental health disorders through mental health promotion. For instance, DBHR provides a series of trainings for community and mental health providers who respond to the needs of returning combat veterans. In the past year, DBHR has facilitated Mental Health First Aid training for community members, for state employees not working in the behavioral health system, and for certified peer counselors.

Legislation
Initiative 502 defines and legalizes small amounts of marijuana-related products for adults 21 and over, taxes it, and designates the revenue for healthcare and substance-abuse prevention and education. As noted at RCW 69.50.101, cannabis is still classified as a schedule I controlled substance under federal law and subject to federal prosecution under the doctrine of dual sovereignty. Possession by anyone younger than 21, possession of larger amounts, and the growing of unlicensed or unregulated marijuana remains illegal under state law. The dedicated marijuana fund for all revenue received by the liquor and cannabis board, and explicitly earmarks any surplus from this new revenue for health care (55%), drug abuse treatment and education (25%), with 1%

for marijuana-related research at University of Washington and Washington State University, most of the remainder going to the state general fund.

Initiative 692 permits the medical use of marijuana by patients with certain terminal or debilitating conditions. Non-medical use of marijuana would still be prohibited. Physicians would be authorized to advise patients about the risks and benefits of the medical use of marijuana. Qualifying patients and their primary caregivers would be protected from prosecution if they possess marijuana solely for medical use by the patient. Certain additional restrictions and limitations are detailed in the measure.

Early Intervention
DBHR has supported early intervention collaborative projects with other child-serving agencies and partners (e.g., DSHS' Children's Administration, local county health departments, and local school districts). These efforts have included funding assistance to Primary Intervention Programs in the schools, counseling collaborations offering evidence-based interventions such as Functional Family Therapy and Aggression Replacement Therapy to at-risk students through the DSHS' Juvenile Rehabilitation Administration, and developing appropriate in-home services for families at risk of child abuse and neglect.

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).

Treatment
Mental Health
DBHR operates the 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. Access to RSN's mental health services is governed by medical necessity and Access to Care Standards (ACS) established by the department and approved by the Centers for Medicare and Medicaid Services (CMS). In general, to meet the ACS criteria, a person must have a covered diagnosis, significant functional impairment, and the requested service must reasonably be expected to improve, stabilize, or prevent deterioration of functioning resulting from the presence of a mental illness.

Several Evidence-based Practice pilots have been tested in the state including Multi-systemic Therapy (MST), Wraparound and Multi-dimensional Treatment Foster Care (MDTFC), Trauma-focused Cognitive Behavioral Therapy (TF-CBT). We are identifying pilot sites for Integrated Dual Disorder Treatment and Illness Management and Recovery.

Substance use disorder
Substance use disorder assessments are performed using American Society of Addiction Medicine (ASAM) Patient Placement Criteria (PPC). 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 PPC. Certified treatment agencies provide the outpatient substance use disorder services in local communities. If the consumer needs residential substance use disorder treatment, referral is made to Washington state's statewide residential treatment system.

DBHR is a recipient of the State Adolescent Treatment Enhancement and Dissemination grant that will allow the opportunity to enhance 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).

Crisis Services
Mental Health Crisis Services are intended to 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.

Mental Health Crisis Services are intended to 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.

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

Recovery Support Services

DBHR recognizes recovery support services as important adjuncts in helping ensure individuals in recovery from chemical dependence 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 critical to embed recovery services within a system of care in which consumers can identify realistic goals, prioritize steps to meet goals, and select services to aid them on their path to recovery.

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

DBHR supports the efforts of over 254 Oxford Houses in Washington state (approximately 2,108 beds). During the last biennium, approximately 5,000 individuals were provided sober housing through Oxford Houses. The Oxford House is based on the concept of promoting alcohol/drug recovery. Oxford Houses are democratically run, self-supporting, and drug-free homes (tenants pay their share of the rent and utilities which averages $380/month). There is no limit on length of stay; the average stay is 12-24 months. Each house represents a remarkably effective and low-cost method of preventing relapse. In Washington state, six outreach workers provide direct services, identify new Oxford Houses, negotiate with property owners, and recruit initial residents. Oxford House tenants receive living skills training, as well as learn processes for establishing new chapters and how to keep focused on Oxford Houses as a place for recovery.

The Permanent Options for Recovery-Centered Housing (PORCH) project provides the evidence-based practice Permanent Supportive Housing (PSH). The target population is adults and young adults in transition, who are homeless, inappropriately housed, exiting psychiatric hospitalization, or at risk of becoming homeless due to serious mental illness (or co-occurring mental and substance use disorders). The PORCH project is a partnership between DBHR, two RSNs, and local mental health and housing provider agencies. The project provides PSH throughout one urban and two rural Washington counties, serving 100 to 150 individuals per year. The PSH project teams provide housing-related support services and other assistance to persons served by the project and assist in the overall implementation of the project, including outreach to perspective participants, the community, partners, and stakeholders.

Another initiative supporting recovery in the past ten years has been Washington state's Project for Assistance in Transition for Homelessness (PATH) Program. PATH is a systematic collaboration between our mental health system and providers of community and government subsidized housing resources. This effort has provided thousands of

units of housing for individuals with mental illness or co-occurring disorders who are homeless or at immediate risk of homelessness.

Residences that are alcohol- and drug-free are provided for women and their children through the Pregnant and Parenting Women (PPW) Housing Support Services. Recovery support and linkages to community-based services are provided through this program. A care plan identifies community supports to maximize recovery. Case management coordinates outpatient substance abuse treatment and facilitates prenatal and post-natal medical care, financial assistance, social services, vocational services, childcare needs, and permanent housing.

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

Washington State's Peer Support Program began training mental health consumers to become Certified Peer Counselors in 2005. Peer support is now provided in every region of the state. The program will expand to train supervising certified peer counselors, to provide continuing education of certified peer counselors, and to develop programs to address under-served populations.

Medicaid infrastructure funding helps Supported Employment programs. DBHR works with two national employment consultation firms (Advocates for Human Potential and the Institute for Community Inclusion) to provide technical assistance for communities interested in improving employment outcomes. Participating communities include approximately 65% of the public mental health consumers in the state. DBHR is working with the University of Washington to increase the skill level and use of Motivational Interviewing by employment specialists, certified peer specialists, and peers from consumer operated services in Clark, King, North Sound, OptumHealth-Pierce, and Peninsula RSNs.

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

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

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

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

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

The Office of Consumer Partnership (OCP) in DBHR expanded from a one-person staff to a team of five who have various types of experience/perspectives as consumers of public behavioral health systems in the state. The members provide children and adult mental health and substance use disorder services. The OCP is a priority within DBHR and the office has a clearly-defined purpose. Some key elements include:

- Providing leadership as a member of the Executive Management Team.
- Advocating for both substance abuse and mental health consumers.
- 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 at DBHR-supported conferences and trainings.
- Assisting with recovery-oriented training, including Certified Peer Counseling training.
- Promoting anti-stigma education.

Strengths and Needs of Washington State's Continuum of Care
DBHR continues to improve services for individuals at risk of and/or experiencing mental health and substance abuse crises through a broad-based System of Care strategy that engages all of our state, local, and community partners.

BHSIA is a partner in Governor Jay Inslee's Results Washington, a focused effort to create effective, efficient, and accountable government. BHSIA has lead responsibility for success metrics under the Healthy Youth and Adults success indicator.

BHSIA's Results Washington success metrics include:

- Increase the number of adults (18 and older) receiving outpatient mental health services from 56,000 to 62,000.
- Increase the percent of mental health consumers receiving a service within seven days after discharge form inpatient settings from 59 percent to 65 percent.
- Increase outpatient substance use disorder treatment retention for adults from average of 68 percent to 70.7 percent.
- Increase outpatient substance use disorder treatment retention for youth from average of 74 percent to 76.2 percent.
- Decrease the percentage of 10th graders who report using marijuana from 19.3% to 18.0%.
- Decrease the percentage of 10th graders who report drinking alcohol from 27.7% to 24.8%.

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

STRENGTHS AND NEEDS OF WASHINGTON STATE'S BEHAVIORAL HEALTH PROVIDERS

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

Washington has a critical shortage of community inpatient psychiatric beds. The practice of temporarily placing psychiatric patients in non-mental health treatment facilities, such as community hospital emergency rooms without access to appropriate mental health treatment – known as psychiatric boarding -- was struck down by the state Supreme Court in August 2014 under a ruling that became effective December 26, 2014. Revisions in WAC 388-865-0526 Single Bed Certification expanded the scope of the use of this certification allowing for a consumer to receive services from a facility that is not currently certified under WAC 388-865-0500. Consistent with the court's decision, DSHS filed a regulation on December 19, 2015, that defines those situations in which a single bed certification is allowable. All of the situations defined in statute require that appropriate mental health care is provided based on an individualized plan of care by a facility that is willing and able to provide services under a single bed certification.

The state is continuing to develop additional certified evaluation and treatment beds for persons meeting involuntary treatment criteria in addition to forge stronger working partnerships with community hospitals and mental health providers to deliver appropriate mental health care in a consumer's home community.

DSHS has been hard at work to identify strategies to open up more evaluation and treatment capacity. At a higher level, DSHS is working on three fronts to comply with a court order to reduce time to get evaluated and receive treatment 1) bring new beds online at the state hospitals, 2) explore options for alternate locations to provide restoration services outside the state hospitals, and 3) hire new evaluators to work in the community.

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

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

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

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

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

THE SYSTEM ADDRESSES THE NEEDS OF UNDER-SERVED POPULATIONS

Addressing the Needs of Racial, Ethnic and Sexual Minorities
DBHR has worked to develop a strong relationship with Washington's 29 federally recognized tribes and three non-federally recognized tribes to improve the behavioral health of tribal members. In accordance with the Department's Administrative Policy 7.01, DBHR must submit an annual state plan that addresses issues common among tribes and Urban Indian programs. Meetings between DBHR staff and tribal governments provide a forum to discuss Government-to-Government protocol, policy impacts, contracting issues, and funding opportunities. The meetings also provide an opportunity to share information and discuss current issues. RSNs are also required to comply with the 7.01 Policy and must submit annual comprehensive plans detailing tribal/RSN relations to DBHR.

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

DBHR uses Block Grant funding to provide trainings to meet the educational requirements for credentialing individuals as mental health specialists. In addition, trainings are available for developmental disability specialists, Native American specialists, and child specialists. The SAPT Block Grant has funded cultural competency trainings for substance use disorder professionals, and DBHR staff is required to attend tribal relations training. DBHR understands that cultural competency must also include specialist services for children, older adults, gay/lesbian/ bisexual/transgender/questioning (GLBTQ) populations, persons with disabilities, and veterans.

The contracts with counties and providers for substance use disorder services require that all services be designed and delivered in a manner sensitive to the needs of ethnic

minorities and/or the youth/family/consumer and their community. Per contractual agreement, providers are to initiate actions to ensure or improve access, retention, and cultural relevance of treatment, prevention, or other services. Contractors are required to take the initiative to strengthen working relationships with other agencies that provide services to underserved or particularly vulnerable populations. Contractors and providers report annually about the actions taken with the identified populations and the building of relationships with other agencies.

Strengths and Needs of the State's Approach to Under-served Populations
DBHR has participated in efforts to enhance our current Suicide Prevention efforts, through partnerships with local RSN crisis intervention providers and integration of mental health response with suicide prevention in high-risk communities.

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

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

There is insufficient or inaccurate information collected on gender identity and on tribal affiliation/membership and this contributes to a feeling of not being respected or included. There is often a reluctance to amend or expand data collection to reflect these needs. Some specific population groups cannot be defined geographically, and for these groups there are no consistent data available (e.g., the population of GLBTQ persons, or children of military families, Native Americans not living on tribal lands) that would contribute to planning of prevention and culturally specific service efforts. The early identification of behavioral health problems in medical and school settings and the development of screening, referral, and outreach protocols is critical.

OVERALL STRENGTHS OF THE BEHAVIORAL HEALTH SERVICES IN WASHINGTON

Overall, DBHR is well positioned for the major changes to come in the health care system. The department has implemented Performance Based Contracting with the intent to continue to improve individual and family experience of care and the quality of services.

SB 5732 and HB 1519 were passed by the 2013 legislature. SB 5732 defines system outcomes for the publically funded behavioral health system – mental health and chemical dependency services. HB 1519 reinforces those same outcomes by applying them to the publically funded medical and long-term care systems as well, with performance measures related to the outcomes adopted and applied across all of these systems.

Washington state emphasizes data driven decision-making for assessment, care coordination, and service implementation. A close collaborator of DBHR, the Research and Data Analysis (RDA) Division of DSHS, has developed an innovative web-based clinical decision support application, Predictive Risk Intelligence System (PRISM). PRISM features state-of-the-art predictive modeling to support care management for consumers with significant health needs. Predictive modeling uses data integration and statistical analysis to identify persons who are at risk for poor health outcomes. For instance, PRISM can identify:

- Adults with multiple complex chronic physical and behavioral health conditions.
- Foster youth with complex medical and behavioral health needs.
- Persons with schizophrenia who do not consistently take their medications and are consequently at increased risk of hospitalization.
- Persons with chronic health conditions who are applying for SSI.

DBHR continues to use demographic and treatment information on consumers receiving publically funded substance use disorder treatment services through the Treatment and Assessment Report Generation Tool (TARGET).

NEEDS ASSESSMENT: DATA-INFORMED DECISION MAKING

The innovative changes in Washington state health care purchasing system driven by state and national legislation are requiring the integration of both mental health and substance abuse (chemical dependency) treatment into a behavioral healthcare model and larger integration of behavioral health services into the primary medical service system. These changes have also driven a change in the business model from a fee-for-service to a managed care model and have changed requirements for data collection and reporting. By April 2016, the MHD-CIS and TARGET systems will be decommissioned and replaced by an integrated Behavioral Health Data Store Consolidation (BHDSC).

By developing an integrated behavioral health data collection, storage and reporting system, the BHDSC project will modernize the flow of data, provide increased security improve accountability and increase transparency of information, management decisions, and policy development. This effort will also strengthen the management of change, monitoring of service delivery quality and outcome analysis for the entire organization and further align the organization to a managed care model. All changes will be integrated into the organization's current IT platforms in order to establish

increased security while allowing all systems and processes to continue without interruption.

DBHR continues to integrate data-informed needs assessment with planning, policy development, service provision, and reporting. The State Epidemiological Outcomes Workgroup (SEOW) plays a critical 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. During the past year, the SEOW has provided guidance, as well as data support in identifying the state's prevention priorities through the State Prevention Policy Consortium.

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

Strategy to Identify Unmet Needs and Gaps
DBHR's planning of prevention and treatment services draws on data from various sources. The biennial statewide **Health Youth Survey (HYS)** provides reliable estimates of substance use prevalence and mental health status among in-school adolescents, as well as risk factors that predict poor behavioral health outcomes. The survey, supported by five state agencies and administered every two years in over 80 percent of the state's public schools, is used by DBHR to estimate prevalence rates at state, county, school district, and even school building levels. The most recent administration of HYS in the fall of 2014 provided data for DBHR's needs assessment, including new indicators that expand surveillance capacity for LGBTQ communities and substance use issues related to new marijuana laws.

For young adults, adults, and older adults, the main data sources for prevalence estimates and epidemiological analyses are **the National Survey on Drug Use and Health (NSDUH)** and the **Behavioral Risk Factor Surveillance System (BRFSS)**. NSDUH is used to estimate and monitor the prevalence rates for different types of substances and BRFSS provides information to identify needs and gaps in various demographic and socioeconomic subpopulations. For example, the Washington BRFSS has questions that allow us to identify pregnant/parenting women and the GLBTQ subpopulation. DBHR has also collected data to assess possible changes in needs in the wake of major policy changes. For example, DBHR added questions in the BRFSS to monitor the use of spirits and medical marijuana in response to recent policy changes. Both NSDUH and BRFSS will be used to estimate the prevalence of mental illnesses among adults.

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

For specific priority subpopulations, we will draw on data from other state surveys and administrative databases. For example, we will use data from the **Pregnancy Risk Assessment Monitoring System (PRAMS)** to estimate the prevalence of substance use among pregnant women. The SEOW will identify data gaps for priority subpopulations and advise on potential data sources.

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

Detailed community level needs and resources assessments will be used to develop strategic plans to support prevention strategies at the individual, community, and local system level. In addition to HYS, the **Community Outcomes and Risk Evaluation (CORE) System** will be used in community level needs assessment. The CORE Geographic Information System (GIS), developed as a set of social indicators highly correlated with adolescent substance use, are kept at the lowest possible level (at least county level, and address level in some instances). Most indicators originate from the Department of Health, DSHS, the Uniform Crime Report, and the Office of the Superintendent of Public Instruction.

Reporting of services on an individual level allows us to identify subpopulations or geographic areas that are unserved or underserved by our current system. It also provides data to monitor vendor performance and track treatment outcomes. The **Treatment and Assessment Report Generation Tool (TARGET)** is DBHR's web-based management and reporting system for chemical dependency client services and provides information on clients and services from substance use disorder agencies throughout the state. The **Consumer Information System (CIS)** collects data on mental health services provided by Regional Support Networks (RSNs) and their subcontractors as well as services provided at the state hospitals. Both CIS and TARGET also collect and report on recovery support services. The **Provider One** system contains medical billing and encounter data for Medicaid clients, including psychiatric hospitalization information. We will use these data systems to evaluate utilization patterns, penetration rates, treatment profiles, and provider and RSN performance (e.g. treatment retention rates). **The Integrated Client Databases**

(ICDB), which contains longitudinal client service histories and outcomes, will support our analyses of client interactions with other DSHS services and client outcomes such as employment and interaction with the criminal justice system. All these factors will inform DBHR's resource allocations.

Strategy to Align Behavioral Health Funding with Unmet Needs and Gaps
It is our goal to build resource allocation decision-making on a data-driven process. On-going epidemiological analyses have already informed strategic planning efforts and current funding allocation formulas.

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

Under the state's Community Prevention Wellness Initiative (CPWI) prevention funding is distributed to communities with the highest needs. Highest need communities are identified by the SEOW based on a risk ranking that integrates prevalence and indicators for consequences related to substance use. The risk rankings will be updated periodically by the SEOW using the latest data. In 2015, the risk rankings were updated using the 2014 statewide student survey; separate rankings were developed for underage drinking, marijuana use, and all ATOD use. Because the HYS and CORE data are available at the community and school level, many rural and hard-to-reach communities are among those in the current set of 52 CPWI communities.

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

Mental health resource allocation 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.

An important aspect of DBHR's surveillance work is the increasingly sophisticated access to data available for providers to help in their own assessment and planning. DBHR has created "the System for Communicating Outcomes, Performance & Evaluation (SCOPE) http://www.scopewa.net," a web-based Mental Health and

Substance Abuse Performance Indicators. This framework consists of two broad functions: 1) standard reports, which typically address issues of general interest to constituents in pre-formatted output and 2) an ad hoc query function that allows users to perform analyses and data summaries using a drop-down menu interface. SCOPE is available to treatment providers, regional administrative entities, state program managers, and the general public. DBHR's SCOPE reporting system has fulfilled and supported the needs and strategy of former "Uniform Reporting System (URS)" and current "Client-Level Data." It has continued to support the monitoring of service access, quality, and utilization as well as consumer outcomes and to identify gaps and areas for improvement.

Current Priorities

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

For substance abuse treatment services, the updated county funding formula based on needs assessment integrates factors which emphasize our focus on the mandated priority populations (IVDU, PPW) and full continuum of care, while retaining our commitment to youth treatment, evidence-based practices, and statewide availability of services.

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

There are two pieces of state legislation that are driving the data, reporting, and performance management priorities for DBHR: (1) **Senate Bill 6312**, which directs DSHS to change how it purchases mental health and substance use disorder services; and (2) **House Bill 1519** and **Senate Bill 5732**, which direct DSHS and the Health Care Authority (HCA) to carry out multiple activities focused on improving the outcomes of adults who receive behavioral health services, including the establishment of accountability measures. To implement this legislation, DBHR is currently working to redesign its data system and align its reporting, performance measures, and quality improvement activities to support the system change to an integrated behavioral health managed care model as required by SB6312. DSHS is currently working towards transitioning to Behavioral Health Organizations (BHOs) which will purchase and

administer public mental health and substance use disorder services starting in April 2016.

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

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

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

Results Washington is Washington Governor Jay Inslee's data-driven performance management and continuous improvement system, which incorporates the best aspects of the former Government Management Accountability and Performance (GMAP) system and Lean principles, and using the latest technology to routinely gather, review, and display data which will make it easier for citizens to find out information about performance within state agencies. Data are provided quarterly.

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 number of adults (18 and older) receiving outpatient mental health services from 56,000 to 62,000 by June 30, 2015.
- Decrease the percentage of 10th graders who report smoking marijuana in the past 30 days from 19.3% in 2012 to 18% by 2017.
- Decrease the percentage of 10th graders who report drinking alcohol in the past 30 days from 27.7% to 24.8% (revised to 19%) by 2017.

- Increase the percent of mental health consumers receiving a service within seven days after discharge from inpatient settings from 59% to 65% by June 30, 2015.
- Increase outpatient chemical dependency treatment retention for adults from the FY 2013 average of 68% to 70.7% by June 30, 2015 (revised to 68.4% by June 30, 2017).
- Increase outpatient chemical dependency treatment retention for youth from the FY 2013 average of 74% to 76.2% by June 30, 2015 (revised to 73.8% by June 30, 2017).

At the direction of Governor Inslee, DSHS has been on a mission to implement Lean management. Each DSHS administration, including BHSIA, developed a Strategic Plan and a series of Lean A3 processes to demonstrate the results of these efforts.

The Department Performance-Based Core Metrics report is a tool to illustrate agency accountability for results. Measures within the report show the agency's performance in its business and management practices. DBHR includes performance-based metrics into its contracts with counties (for outpatient chemical dependency treatment retention) residential providers (for residential chemical dependency treatment completion), and RSNs (for timely transitioning between inpatient and routine outpatient mental health services). The performance data is provided to contract managers who use it in their monitoring activities.

The BHSIA Strategic Plan outlines a commitment to be the national leader in providing successful mental health services in state psychiatric hospitals and community settings and successful chemical dependency inpatient and outpatient treatment, recovery and prevention services. This format, using colors, provide a snapshot on the status of achieving each Core Metric; for example: Green – on track, yellow – needs attention, and red – critical.

	2012	2013	2014	
Provide successful mental health services in state psychiatric hospitals	RED	YELLOW	YELLOW	Capital needs are severe. Psychiatrist retention and recruiting is problematic. The forensic system has constitutionally unacceptable backlogs. Operating costs and budgets are not stable. Significant practice and staffing changes, increased focus on assault reduction and increased training position the hospitals well for the future.
and community settings and	RED	YELLOW	GREEN	Psychiatric boarding was eliminated for adult and child psychiatric patients in 2014. Community-based programs to treat children whose serious mental illnesses places them at risk of instiutionaliztion began in 2014. Washington's implementation of the Affordable Care Act has significantly expanded access to community mental health services.
successful chemical dependency treatment, recovery and prevention services.	YELLOW	YELLOW ↑	YELLOW ↑	2014 Medicaid expansion and I-502 (marijuana legalization) revenues for youth substance use prevention and treatment will expand access to services. Creation of Behavioral Health Organizations that integrate chemical dependency and mental health services, performance-based contracts and actuarially sound rates are the foundation for major performance improvements.

At the performance metric level, BHSIA-DBHR demonstrates the following results:

	2012	2013	2014	
Increased state psychiatric hospital treatment hours	YELLOW	YELLOW	YELLOW	
Decreased state psychiatric hospital seclusion and restraint rates	YELLOW	YELLOW	YELLOW	
Decreased state psychiatric hospital assault rates	RED	RED	YELLOW	
Timely competency evaluations	RED	RED	RED	Staffing levels must increase to meet growing demand. Unconstitutional conditions exist for some forensic (criminal justice system) patients.
Availability of adult outpatient mental health services	YELLOW	YELLOW	GREEN	More than 9,000 new mental health clients have gained access to services. Psychiatric boarding has been eliminated. RESULTS WASHINGTON
Timely outpatient mental health services	YELLOW	YELLOW	YELLOW ↑	Taken as a whole, Washington has strong performance although some county-based Regional Support Networks lag. RESULTS WASHINGTON
Availability of child outpatient mental health services	YELLOW	YELLOW ↑	GREEN	Children whose mental illness places them at risk of institutionalization will now have access to intensive wrap-around services.
Use of evidence-based chemical dependency prevention programs	YELLOW	YELLOW	YELLOW	
Increase employment for chemical dependency clients	GREEN	GREEN	GREEN	Increase in employment post-treatment.
Outpatient adult chemical dependency retention	GREEN	GREEN	GREEN	Maintaining high treatment rates with limited funding. RESULTS WASHINGTON
Outpatient child chemical dependency retention	GREEN	GREEN	GREEN	Maintaining high treatment rates with limited funding. RESULTS WASHINGTON

PUBLIC COMMENT ON THE STATE PLAN (TO BE COMPLETED AT A LATER DATE

Tribes

Stakeholders

Consumers

PRIORITY AREAS AND ANNUAL PERFORMANCE INDICATORS

Priority Area and Annual Performance Indicators (Results Washington)
If a state is unable to achieve the goals as stated in its application approved by SAMHSA, the state will be asked to provide a description of corrective actions to be taken. If further steps are not taken, SAMHSA may ask the state for a revised plan, that SAMHSA will assist in developing, to achieve the goals.

Priority 1:	**Reducing Underage Substance Use**
Goal of the priority area:	Decrease the percentage of 10th graders who report using alcohol, marijuana, tobacco, and other drugs in the last 30 days.
Strategies to attain the goal:	• Implement performance-based contracting with CPWI coordinators. • Require strategic plans from each CPWI. • Adapt programs to address the unique needs of each tribe. • Expand SBIRT in health care, school, and community settings if feasible.
Annual Performance Indicators to measure goal success:	Maintain the number of Washington youth receiving direct prevention services from baseline: SFY15 34,219
Baseline measurement:	Washington State Healthy Youth Survey, 2014
First-year target:	Maintain number of prevention programs and participants from SFY15 baseline numbers: • 77 Community-wide programs implemented. • 28 Programs focused on addressing favorable attitudes. • 34,219 Individuals reached. • 1,569 Hours of technical assistance provided to CPWI sites. • 48 Youth teams made up of 298 individuals attending the Prevention Summit.
Second-year target/outcome measurement:	• Show decrease in substance use in 10th graders according to the Washington State Healthy Youth Survey, 2016. • Increase the number of prevention programs and participants from SFY15 baseline numbers: ○ Community-wide programs implemented. ○ Programs focused on addressing favorable attitudes. ○ Individuals reached. ○ Hours of technical assistance provided to CPWI sites. ○ Youth teams and individuals attending the Prevention

	Summit. • Determine feasibility of piloting and implementing SBIRT-like services in school-based settings.
Data source:	Washington State Healthy Youth Survey, 2014
Description of data:	10th Grade Substance Use Among Washington Youth
Data issues/caveats that affect outcomes:	• Community Laws and Norms make use favorable | 1998 passage of Medical Marijuana, 2012 passage of recreational marijuana, 2011 passage of privatized liquor, lack of enforcement of school policies, adult/parental attitudes favorable toward use • Availability |The cost is not prohibitive, prevalence of marijuana dispensaries, inability to identify marijuana-infused products, it's easy to get (68% Seattle SD HS students get it from friends, 39% get it from medical marijuana dispensaries). There are more stores selling liquor (I-1183 resulted in increase from 328 to 1415 stores), it's easy to get (15% of 10th graders get it from home with approval, 19% give someone money to buy it, 20% take it from home without permission, 31% get it at parities, 37% get it from friends) • Favorable Attitudes | Youth think they won't get caught, parents/adults have favorable attitudes toward marijuana use, youth don't perceive harm (decrease of 66% since 2006), peers and adults have favorable attitudes, (28% decrease since 2006 of youth think it is wrong to use marijuana). Youth who use alcohol think they won't get caught, parents/adults have favorable attitudes toward alcohol use, youth and adults don't perceive harm of drinking, peers have favorable attitudes toward alcohol use • Traumatic Childhood Experiences | Family history of substance abuse, divorce, mental illness, domestic violence, physical, sexual or emotional abuse or neglect increase risk

Priority 2:	
Goal of the priority area:	Increase percentage of youth outpatient chemical dependency treatment retention in youth from a state fiscal year average of 74.2% to 76.2%.
Strategies to attain the goal:	Explore new mechanism and protocols for case management

	and Continue using Performance Based Contracting to improve retention in Youth Outpatient, increase contracted target, and add technical assistance tools for use by providers
Annual Performance Indicators to measure goal success:	Adult CD Outpatient Caseload & Adult Outpatient Treatment Retention by Governing County.
Baseline measurement:	
First-year target:	Workgroup to review identified countermeasures for feasibility and potential impact
Second-year target/outcome measurement:	Convene internal workgroup to establish timeline, implementation plan, and actual products for implementation
Data source:	SCOPE/TARGET/Treatment Analyzer
Description of data:	"SFY2013 Served" is an unduplicated count of youth (persons 17 years of age and younger) served in publically-funded outpatient treatment between July 1, 2012 and June 30, 2013.
Data issues/caveats that affect outcomes:	• Lack of case management ability by the treatment programs for issues such as client engagement, money for transportation, and assistance to get into supportive housing • Youth outpatient clients not currently being retained at the rate that is set • There is not additional funding to implement trainings recommended by the A-3 workgroup

Priority 3:	
Goal of the priority area:	Increase percentage of mental health consumers receiving a service within 7 days after discharged from inpatient settings from 59% to 65%.
Strategies to attain the goal:	• Guidance to RSNs/MH providers to increase the use of the Rehabilitation Case Management and Crisis Stabilization modality • Work on definition and develop baseline for 30-day psychiatric re-hospitalization measure under SB5732 and HB1519 work • Align the 7-day measure definition with the "new" 30-day measure
Annual Performance Indicators to measure goal success:	Increase the percentage of consumers in mental health services within 7 days of inpatient discharge
Baseline measurement	RSN Service Data
First-year target:	• Identify issues with 7-day measure to exclude what cannot be controlled • Focus on developing 30 day readmission measure • Improve hospital notification of RSN of admissions (TPL

	and Duals) • Increase providers' use of Medicaid modalities that can be provided prior to intake and promote linkage from inpatient to outpatient settings
Second-year target/outcome measurement:	• Include 30-day measure in the BHO contracts including expectations for performance • Increase providers' use of Medicaid modalities that can be provided prior to intake and promote linkage from inpatient to outpatient settings. • Analyze racial/ethnic disparities for 7-day and 30-day readmit measures
Data source:	RSN Service Data
Description of data:	Measure of the percentage of Medicaid enrollees who are seen for a face-to-face appointment within 7 days of discharge from a psychiatric facility
Data issues/caveats that affect outcomes:	• Hospitals fail to alert RSN of admission when there is co-insurance (if RSN doesn't authorize stay, they may not know individual is in hospital) • Discharges to non-RSN providers (in-patient CD treatment, VA facilities, other non-RSN contracted providers)

Priority 4:	
Goal of the priority area:	Increase number of adults (18 and over) receiving outpatient mental health services from 56,000 to 62,000
Strategies to attain the goal:	• 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 and located through Geo-mapping and other available data systems • Convene Service Engagement Workgroup to address engagement in treatment at intake
Annual Performance Indicators to measure goal success:	Increase the number of adults (18 and over) receiving outpatient mental health services
Baseline measurement:	RSN service data third quarter FY 2103
First-year target:	• Assemble population analysis to inform Medicaid Enrollment Workgroup • Convene Medicaid Enrollment Workgroup to determine best practices • Gather data to show impact of in-person supports/potential data for funding requests for ongoing in-person supports (in-person assisters)

	• Convene Service Engagement Workgroup to address engagement in treatment at intake
Second-year target/outcome measurement:	• Improve access in underserved areas • Improve engagement at intake
Data source:	RSN service data
Description of data:	The number of adults (18 and over) receiving outpatient mental health services
Data issues/caveats that affect outcomes:	• Lack of in-person supports to help consumers • Lack of consumer enrollment in Medicaid at first contact • Intake process not customer focused • Geographical access issues • Lack of marketing and education about services • Slow and often unsuccessful transitions across system

Priority 5:	
Goal of the priority area:	Increase percentage of outpatient substance use disorder treatment retention in adults from 68.7% to 70.7%.
Strategies to attain the goal:	Explore new mechanism and protocols for case management and continue using Performance Based Contracting to improve retention in Adult Outpatient, increase contracted target and add technical assistance tools for use by providers
Annual Performance Indicators to measure goal success:	Adult CD Outpatient Caseload & Adult Outpatient Treatment Retention by Governing County
Baseline measurement:	
First-year target:	Workgroup to review identified countermeasures for feasibility and potential impact
Second-year target/outcome measurement	Convene internal workgroup to establish timeline, implementation plan, and actual products for implementation
Data source:	SCOPE/TARGET/Treatment Analyzer
Description of data:	"SFY2013 Served" is an unduplicated count of adults (persons 18 years of age and older) served in publically-funded outpatient treatment or Opiate Substitution Treatment between July 1, 2012 and June 30, 2013.
Data issues/caveats that affect outcomes:	• Lack of case management ability by the treatment programs for issues such as client engagement, money for transportation and assistance to get into supportive housing • Adult outpatient clients not currently being retained at the rate that is set above

Priority 6:	
Goal of the priority area:	Decrease number of homeless people from 17,775 to 16,000 (10% reduction)
Strategies to attain the goal:	
Annual Performance Indicators to measure goal success:	
Baseline measurement:	
First-year target:	
Second-year target/outcome measurement:	
Data Source:	
Description of data:	
Data issues/caveats that affect outcomes:	

Priority 7:	
Goal of the priority area:	Increase the number of youth receiving outpatient mental health services
Strategies to attain the goal:	Increase the use of wraparound community based mental health services and supports Enhance transition planning to reduce inpatient utilization
Annual Performance Indicators to measure goal success:	The number of youth receiving outpatient mental health services will increase each quarter while maintaining or decreasing inpatient utilization
Baseline measurement:	Third quarter FY13 average of 23,000
First-year target:	Implementation of Wraparound with Intensive Services (WISe)
Second-year target/outcome measurement:	Implement the use of CANS
Data source:	Mental Health Consumer Information System (CIS), via the System for Communicating Outcomes, Performance and Evaluation (SCOPE-WA)
Description of data:	Number of Medicaid and Non-Medicaid youth (under age 18) receiving (1) outpatient mental health services and (2) inpatient (i.e., Community Hospital Psychiatric Unit services or Evaluation and Treatment [E&T] Center) services from RSNs; and (3) inpatient services from the Child Study and Treatment Center (CSTC) and the Children's Long-Term Inpatient Program (CLIP).
Data issues/caveats that affect outcomes:	Wraparound services not available statewide and lack of uniformity on acute care policy and utilization

Priority 8:	
Goal of the priority area:	Increase rates of employment and earnings for that receiving BHSIA-funded chemical dependency treatment.
Strategies to attain the goal:	
Annual Performance Indicators to measure goal success:	
Baseline measurement:	
First-year target:	
Second-year target/outcome measurement:	
Data source:	
Description of data:	
Data issues/caveats that affect outcomes:	

HEALTH DISPARITIES

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

Addressing the Needs of Racial, Ethnic and Sexual Minorities
DBHR has worked to develop a strong relationship with Washington's 29 federally recognized tribes and three non-federally recognized tribes to improve the behavioral health of tribal members. In accordance with the Department's Administrative Policy 7.01, DBHR must submit an annual state plan that addresses issues common among tribes and Urban Indian programs. Meetings between DBHR staff and tribal governments provide a forum to discuss Government-to-Government protocol, policy

impacts, contracting issues and funding opportunities. The meetings also provide an opportunity to share information and discuss current issues.

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

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

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

EVIDENCE-BASED PRACTICES FOR EARLY INTERVENTION (5%)

DBHR continues to work closely with the Early Assessment and Support Alliance (EASA) Technical Assistance Team on pilot site implementation, clinical consultation, and statewide education and outreach. EASA is an early psychosis transitional program based in Oregon State. EASA was created in 2001 with the goal of reducing long-term disability associated with psychosis and has two primary components: a clinical team and a community network.

EASA clinical teams work to achieve the following:

- Identify people who are experiencing psychosis as early as possible.

- Establish a trusting relationship based on respect and genuine belief in the person's ability.
- Provide a comprehensive and accurate assessment of the person's medical condition, strengths, goals and needs.
- Stabilize the person's symptoms and living situation.
- Preserve the person's family and informal support.
- Help the person and family develop the skills, knowledge and social support needed to be successful in managing the condition in the long-run.
- Successfully transition young people to ongoing supports and services in the community.
- Continually solicit the learning of those they serve and integrate that knowledge into program development.

Much like EASA, we are leaving room for our pilot program to evolve based on feedback, experience and availability of new methods. For example, EASA is now integrating methodology from evidence-based "toolkits" developed by the U.S. Substance Abuse and Mental Health Administration (SAMHSA). Toolkits being implemented at our pilot site include multi-family groups, Individual Resiliency Training, dual diagnosis treatment (chemical dependency and psychosis), and supported employment. We are working collaboratively to tailor the EASA model to best meet the needs of youth and families in our state, and are extremely fortunate to bring their high level of experience and expertise to the planning process.

We will continue to work with the EASA Technical Assistance Team in Federal Fiscal Year 2016 to provide ongoing community education, training and technical assistance to individuals and organizations to assist in developing effective services for young people with psychosis.

Central Washington Comprehensive Mental Health (CWCMH) was selected as the pilot site in February 2015 and was able to include family and youth system partners to create a name - New Journeys Early Intervention Program. CWCMH was an excellent match for the pilot project based on several key components required to develop a strong Early Psychosis Team. These characteristics include a wellness, recovery and resilience orientation; access to inpatient hospital care; linkages with community resources and outreach capabilities; strong psychiatric supervision and clinical leadership and a willingness to work collaboratively to develop a model that would best serve their community, in addition to assisting in developing the frame work for a statewide model.

A small set back has delayed the original start date of July 2015 to August 2015 due to workforce shortages. While CWCMH has successfully hired two bi-lingual team members and have identified a program director, they are still working to fill the remaining team position.

At the recommendation of the EASA, the New Journeys' team will be receiving Individual Resiliency Training (IRT), a modular-based intervention for helping individuals identify and enhance their strengths and resiliency factors, increase their illness management skills, and learn skills to increase their success in achieving personal goals, such as employment, education, and positive relationships. IRT is the primary component of the NAVIGATE program model that was developed with support from the National Institute of Mental Health (NIMH) and is one of the Coordinated Specialty Care (CSC) models options endorsed by SAMHSA.

The New Journeys' Pilot Program, continues to deliver statewide presentations and work collaboratively with stakeholders and system partners to increase awareness of early psychosis, while increasing the level of resources and information available to individuals who engage with and serve transition age youth. Along with the presentations and trainings, the New Journeys' Pilot Program will be launching two statewide early psychosis initiatives in August 2015:

1. **QPR for Psychosis:** New Journeys is partnering with The QPR Institute to offer an online opportunity for mental health agency staff, school and juvenile justice personnel to be trained as QPR Gatekeeper Instructors. QPR Gatekeeper Training for Suicide Prevention is the most widely taught gatekeeper training program in the world. First Episode Psychosis (FEP) is associated with increased risk of suicidal behaviors in youth. The QPR Institute has modified this training for Washington to include early recognition and response to young people who may be experiencing FEP.

   The QPR intervention (how to Question, Persuade, and Refer someone who may be at risk of suicide or psychosis), is designed to achieve four outcomes:

   - Early recognition of signs of distress, including suicide and psychosis warning signs
   - Early intervention and referral
   - Early assessment
   - Early treatment

2. **RecoveryLibrary™:** New Journeys is partnering with Pat Deegan and Associates to provide extensive early psychosis online resources and materials for up to 2,500 mental health providers, Juvenile Justice, Mental Health providers, and school (High School, Community/Technical Colleges, and State Universities and Colleges) for a two-year period. RecoveryLibrary is an online resource for those who want to pursue recovery and wellness, and for those who want to help others achieve it. Under the leadership of Patricia E. Deegan, PhD, the library is designed to bring the hope, the tools, and the inspiration for recovery to all. RecoveryLibrary addresses a variety of mental health, wellness,

and addiction recovery topics. It features thousands of multi-media resources that are optimized to work on computers and tablets.

New Journeys is committed to increasing awareness of early psychosis identification and intervention. The pilot site was an excellent first step. The New Journey's program will be launched in Yakima County. There is an immediate need to increase statewide awareness and education, and QPR for Psychosis Gatekeeper Training and the RecoveryLibrary ™ will share this important information and provide critical tools and resources to the key people who are most likely to engage with transition age youth who might be experiencing a first episode of psychosis. The resources and approach will allow training of 100 Gatekeeper instructors, who will then be able to train a minimum of 2,000 community members across the state in the QPR for Psychosis Gatekeeper training. The RecoveryLibrary™ will provide online access to a variety of early psychosis materials for up to 2,500 mental health agencies across the state. New Journeys Early Intervention Program, QPR for Psychosis and the RecoveryLibrary will continue to be available through 2017.

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

Washington is one of ten states selected to participate in the **National Behavioral Health Council's Early Onset Schizophrenia Community of Practice (CoP)**. The following agencies are included in the Washington State CoP Team:

- **Ann Christian**, CEO, Washington Community Mental Health Council
- **Joan Miller,** Policy Advisor, Washington Community Mental Health Council
- **Haley Lowe**, Behavioral Health Program Administrator, Division of Behavioral Health and Recovery
- **Isabel Jones**, Medicaid Transformation Specialist, Health Care Authority
- **Sue Grinnell**, Special Assistant/Health Transformation and Innovation, Department of Health

The primary outcome of the CoP is the collaborative development of a strategic plan that includes:

- **Community partnerships as referral sources:** Identify state and community resources that can be utilized as the point of screening and/or referral for screening.
- **Clinical portfolio:** Identify current treatment capacity and gaps, staffing and workflow adjustments, and specific clinical areas in need of expansion. As a participating site, we have access to an overview of clinical best practices for this target population.
- **Financing:** Identify funding sources, compliance and documentation requirements.

- **Organizational culture:** Identify necessary adaptations to organizational practices needed to best serve this population and their families and/or social supports.

The pilot site and combined education and outreach efforts, are investments that will produce positive outcomes to improve early psychosis identification outreach, identification, and treatment in our state.

Planned activities for 2016 and 2017, including priorities, goals, objectives, implementation strategies, performance indicators, and baseline measures.

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

The overarching goals of the RDA and UW evaluation and research project are to examine the effectiveness of the early psychosis model being developing in Washington State, as well as conceptualizing the needs and adaptations that will allow sustainable implementation at rural, suburban, and urban sites. In order to create an effective model, there will be careful measurements of the development of the novel interventions and chosen interventions to effectively delay or prevent psychosis and/or improve the course of the illness in those who already have psychosis.

Some of the questions, specific to early psychosis and transition age youth that will be measured and analyzed:

- The current Duration of Untreated Psychosis (DUP) in Washington. The national average is 74 weeks, how can early identification be increased and reduce DUP?
- How to train providers to better predict future psychosis based on early warning signs?
- The length of time from referral to treatment, how to increase referrals and early identification?
- The factors affecting length of hospital stay and likelihood of readmission.
- How initial pilot site outcomes compare to those in other parts of the US and in other countries.
- The influence of insurance coverage and health care reform on available interventions and outcomes for early psychosis.
- The value of various assessments and evidence based approaches to care for and treat positive and negative symptoms of early psychosis.
- What worked well at the New Journeys Pilot Site and what were the challenges?
- Effective outreach methods, where referents are being identified, and who is making the referrals.

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

In addition to the evaluation and research project being conducted by UW School of Medicine and RDA outlined above, RDA will also provide assistance to enhance the capacity of our current data system to identify adolescents and young adults who experience a first episode of psychosis. A program code will be added to the current data collection to identify participants and services provided under this program and will be used for program monitoring. The Department of Social and Health Services (DSHS) and RDA maintain an Integrated Client Database (ICDB) which is created by extracting and matching client records for DSHS clients from administrative data collected by DSHS and other state agencies that serve Washington residents. For each client, the ICDB includes service history, demography, medical diagnoses, prescription drug use, mental illness indicators, as well as outcome measures in the areas of criminal justice, employment, and physical health. The data on program participants and services collected by DBHR will be linked to the ICDB to study program effectiveness.

Budget showing how the set-aside and additional state or other supported funds, if any, for this purpose.

First Episode Psychosis Contracts and Budget	2014/15
Pilot Site Training/EASA	$40,005
Dr. Lisa Dixon: OnTrack NY	$2,000
QPR Institute	$88,300
Pilot Site Funding NAVIGATE Individual Resiliency Training	$137,057 $9,500
Statewide Outreach and Education Campaign	$80,000
Statewide Clinical Training (recovery library)	$9,900
UW School of Medicine, Department of Psychiatry and Behavioral Health	$60,000
Conference, Travel, Training expenses	$10,000
Total dedicated funds (including care coordinator salary and benefits)	$519,262
5% Set Aside Budget Total	$521,452

First Episode Psychosis Contracts and Budget	2016/17
Care Coordinator Salary and Benefits	$82,450
Ongoing Consultation/EASA	$25,000
New Journeys Pilot Site Funding	$314,000
UW School of Medicine, Department of Psychiatry and Behavioral Health: Research and Evaluation	$60,000
RDA	$35,000
Conference, Travel, Training expenses	$5,000
Total dedicated funds	$521,450
5% Set Aside Budget Total	$521,452

PROGRAM INTEGRITY

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

DBHR also provides support and assistance to the counties/tribes and residential agencies in their efforts to combat fraud and abuse and promote best practices to enhance awareness of fraud, waste, and abuse.

Contract requirements are passed down to subcontractors in all subcontracts; this is reviewed and discussed prior to the subcontract being sent out to a provider. It is then discussed and reviewed during contract monitoring. Generally a review is once per year or once per biennial contract. If additional reviews are needed due to a high risk, audits are done more frequently. Monitoring the appropriate use of block grant funds and oversight practices include:

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

Outpatient services provide by a county subcontractor or tribe program receive reimbursement using a fee for service model. All services billed for block grant funding are confirmed through data entered into the TARGET data system.

The residential treatment programs use a different payment structure. Services are paid on a per patient, per day basis. Bed days are allocated to each residential provide for each fiscal year, bed utilization is monitored monthly and funding is transferred based on utilization each quarter.

All programs that receive block grant funding receive an on-site monitoring visit no less than once per biennium, if there is an issue related to utilization or services provided a corrective action plan is initiated and monitoring visits may occur more frequently.

TRIBES

Washington State Department of Social and Health Services established consultation protocols in collaboration with the Indian Policy Advisory Committee (IPAC). IPAC is an advisory committee with representatives from the 29 Federally Recognized Tribes and

Recognized American Indian Organizations (RAIO) in Washington State. These protocols are:

Consultation Protocol: Between the Department of Social and Health Services, Tribal Governments, and Recognized American Indian Organizations (RAIO)

Purpose:
In accordance with the Centennial Accord and Administrative Policy 7.01, the department maintains a commitment to consultation. Consultation is a formal Government-to-Government meeting to provide an opportunity for an exchange of information and opinion prior to a decision.

Round tables and work groups should be used for discussions, problem resolution, and preparation for consultation. When matters are resolved by using the round table and work group processes, notification of any outcomes to these meetings will be distributed to the affected administration, Office of Indian Policy, tribes, and RAIO in accordance to these written directions.

For the development of the Block Grant Submission, the Division of Behavioral Health Recovery (DBHR) office sent our first letter to the tribal leadership on July 2, 2015, announcing a consultation meeting on August 18, 2015, between the secretary of DSHS and tribal leaders. The natural conduit for ongoing communications is the Indian Policy Advisory Council (IPAC) sub-committee. DBHR is committed to participation in these meetings to further develop and finalize the plan.

Within Washington state, the tribes have been working with the department on a Tribal Centric Behavioral Health System. This ongoing endeavor will form the foundation for further development and integration of mental health treatment, substance abuse treatment, and primary care. The Tribal Centric workgroup includes representatives from DBHR, the department, IPAC, the American Indian Health Commission and the North West Portland Area Indian Health Board.

DBHR is committed to maintaining a strong intergovernmental relationship with the tribes of Washington state and to the development and delivery of beneficial services to Indian families and individuals in need. DBHR recognizes the critical importance and vital need to work in partnership with tribes and Urban Indian communities across the state to ensure that Native American people have equitable access to behavioral health services and that the services are culturally sensitive and appropriate.

Tribal representation is integral to ensuring that DBHR is able to meet the needs within tribal communities. The Department's Office of Indian Policy (OIP) and IPAC assist DBHR in reaching out to tribal members to participate on each advisory council.

PRIMARY PREVENTION FOR SUBSTANCE ABUSE

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

The purpose of the SEOW is to support the development and use of robust and meaningful measures that allow data-driven policy decisions and program planning to reduce substance abuse and promote mental health. These measures provide information on the full spectrum of indicators including risk and protective factors, and long-term health and social consequences of substance abuse or mental illness.

The SEOW collects and provides guidance on the collection of various types of data related to substance use and mental health, including consumption/prevalence, consequence, and intervening variables. Please see the table below for more details.

Table 1 SEOW Data Sources

Data Source	Types of Data On Substance Use	Target Populations
WA Healthy Youth Survey • State-developed school-based student survey • Biennial since 2002	Consumption: • Alcohol, tobacco, marijuana, prescription drug, other illicit drugs: current use, lifetime use, age at first use, level of use, use at school. Consequence: • Depressive feelings, anxiety, suicide and suicide attempts; • Youth delinquency; • Motor vehicle safety; • School attendance, academic performance. Intermediate: • Risk and protective factors.	• WA 6th, 8th, 10th, and 12th graders in all public schools; • In small school districts, 7th, 9th, 11th graders are also eligible to participate in 2014; • All race/ethnicity groups; • Rural and urban communities.
BRFSS • Core questionnaire • State-added questions	Consumption: • Alcohol: alcohol consumption module, use of liquor • Marijuana: current, lifetime use; mode of use, medical marijuana use • Prescription drugs: use of pain killers Consequence: • Drinking and driving; driving under the influence of marijuana	• Adults 18 and above; • All race/ethnicity groups.

Data Source	Types of Data On Substance Use	Target Populations
NSDUH state estimates	Consumption: • Alcohol, tobacco, marijuana, prescription pain relievers, illicit drugs Consequence: • Dependence or abuse Intermediate: • Perception of risk in binge drinking, smoking marijuana and cigarettes	• Youth, young adults, and adults
WA Young Adult Health Survey • State-developed internet-based survey • Annually 2014, 2015	Consumption: • Extensive set of questions on marijuana use rates and use patterns • Rates and use patterns of alcohol, tobacco, heroin and pain relievers Consequence: • Physical and mental problems caused by marijuana and alcohol use • Driving under the influence of marijuana Intermediate: • Perception of access, risk, and norms about the use of marijuana, alcohol, heroin, and pain relievers	• Young adults 18-25 • All race/ethnicity groups • Urban and rural areas
The Community Outcomes and Risk Evaluation (CORE) System • Archival indicator database and reports • Updated twice a year	Consequence: • Alcohol and drug related deaths • Criminal justice involvement • School attendance and academic outcomes • Alcohol-related traffic fatalities • Clients of alcohol and drug treatment services Intermediate • An extensive set of variables in community, school, family, and individual domains	• Youth, adults, family, community, schools • Reported at the state, county, locale, and school district levels

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

Strategic Planning

The state has a current Substance Abuse and Mental Health Promotion Five-Year Strategic Plan that was developed in 2012 and updated in 2013. The plan is currently being updated with the 2014 Healthy Youth Survey and Core GIS data and resources assessment. This is projected to be completed by late summer 2015.

The current plan can be found at http://www.theathenaforum.org/spe_policy_consortium_state_substance_abuse_prevention_and_mental_health_promotion_plan_update_march

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

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

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

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

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

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

The Data Books contain the following:

<u>The Community Outcomes and Risk Evaluation Information System (CORE)</u>
The CORE contains archival indicators (or social indicators) that are highly correlated with adolescent substance use, and the risk factors that predict substance use. There are currently 47 indicators, most of which originate from the Department of Health, Department of Social and Health Services, Uniform Crime Report, and the Office of the

Superintendent of Public Instruction. The data are published twice a year on a public website, and reported at the lowest feasible geography level: state, county, school district/community, and locale (a geography that incorporates more than one school district when the base population of the school district is too low for reliable reporting). See https://www.dshs.wa.gov/sesa/research-and-dataanalysis/community-risk-profiles.

Washington State Healthy Youth Survey (HYS)

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

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

Community Readiness

Using the ranked risk profiles, counties were instructed to follow a selection process that would identify communities that were at a high enough level of readiness to benefit from services, while being underserved and at a high-need for services. This readiness was assessed by community support for developing and implementing the CPWI. This was determined by documenting support from at least eight (8) of the twelve (12) required community representative sectors that serve or live in the defined community and agree to join the coalition. Additionally, School District support was assessed and documented to house and leverage funding to support the required match costs for the Prevention/ Intervention specialist in the middle and or high school in the community.

Allocation Formulas

Native American Tribes are offered a set allocation based on a long-standing tribal enrollment calculation. The Indian Nation or Tribal Government determines how much of the overall allocation is used for substance abuse treatment services and how much is used for substance abuse prevention services. These figures are taken into account to maintain the set-aside percentages for prevention services.

Community Prevention and Wellness Initiative (CPWI) communities were determined using a ranked risk profile of each school district in each county consisting of 26 indicators. The indicators are comprised of youth alcohol consumption rates, socio-economics, family risk and other school consequence data. The local county prevention staff and Educational Service District Staff used the ranked risk profiles to select the highest need communities in their county. The number of communities required to be supported with SABG funds and involved in CPWI was calculated based on population. All counties are required to support and maintain at least one CPWI community coalition and school partnership.

Funds allocated to the counties using county client service contracts are required to be focused on the identified CPWI community following a strategic plan that has been approved by the state. Strategic plans are designed to address each step of the Strategic Prevention Framework and include plans for cultural competence and capacity building within each step.

Workforce Capacity

DBHR has a multitude of opportunities in place for communities and prevention providers to build capacity by accessing training from DBHR. There are currently two staff with concrete assignments to oversee the workforce development and to implement the training plan. The training plan is developed based on semi-annual survey of the prevention providers to assess needs and interest in training. Monthly one-hour training sessions following the on-line monthly CPWI Learning Community Meetings are part of the training plan. While attendance in the training session is optional, they have all been very well attended, reaching on average around 50 people per month.

DBHR supports ongoing Substance Abuse Prevention Skills Training at quarterly intervals. There is a contractual requirement for all Community Prevention and Wellness Initiative (CPWI) Community Coalition Coordinators to attend a SAPST training within six months of hire. There are currently two staff with concrete assignments to oversee the workforce development and to implement the training plan.

DBHR staff offer unique webinar trainings in a series that addresses training needs for the CPWI Community Coalition Coordinators to access live help and resources as they implement the Strategic Prevention Framework. The webinar series is part of the enhancement efforts that are also supported by the Partnerships for Success 2013 grant. These presentations are also posted on the Athena Forum Website, a prevention professional website that DBHR maintains. Also available on this website are valuable guidance documents and resources related to all aspects of substance abuse prevention and mental health promotion. This includes access to E-Learning courses that DBHR developed.

DBHR has two major conference trainings. One, an annual Prevention Summit that provide cutting-edge information on prevention research and practices as well as a

forum for providers to develop new skills for implementing prevention services. The other is a Coalition Leadership Institute that is designed to enhance community coalition development and maintenance skills.

In addition to formal presentations and training opportunities, with SAPT funding DBHR supports six Prevention System Managers to provide regular and timely technical assistance to the prevention workforce. CPWI communities use technical assistance for strategic plan development, action plan updates, and SPF implementation.

Evidence-Based Programs
The state has an evidence-based workgroup that determines evidence-based practices and strategies. Comprised of members from the prevention research sub-committee, SEOW, and academic partners the group reviewed evidence-based programs and practices that directly and indirectly impacted youth marijuana use and abuse.

We have a standing Memorandum of Agreement with the SSA in Oregon State to maintain the evidence-based program and practices list that is posted on the Athena forum website. http://www.theathenaforum.org/learning_library/ebp. Sub-recipients for primary prevention services select from this list. The contract requires a minimum of 60% of prevention programs be evidence-based.

The following table of evidence-based, primary prevention programs, practices and strategies will be implemented at the local level through the Community Coalitions and Tribal Nations. Each CPWI sub-recipient develops a local Strategic Plan Tribes develop work plans that address local tribal needs and are reviewed and approved by the state prior to implementation. There are additional innovative programs that are supported with SABG funds at the local level; all of which must follow the CSAP Principles of Effectiveness. The Strategic Action Plans are developed using the Strategic Prevention Framework steps. Following a community needs and resource assessment, gaps analysis and prioritization process, the communities identify their local conditions and strategies.

EBP Curriculum	**CSAP Strategy**
All Stars	Prevention Education
CAST (Coping And Support Training)	Prevention Education
Class Action	Prevention Education
Community Trials Intervention To Reduce High-Risk Drinking	Environmental
Curriculum-Based Support Group (CBSG) Program	Prevention Education
Family Matters	Prevention Education
Good Behavior Game (GBG)	Prevention Education

Guiding Good Choices	Prevention Education
Healthy Alternatives for Little Ones (HALO)	Prevention Education
Incredible Years	Prevention Education
Keep A Clear Mind (KACM)	Prevention Education
LifeSkills Training (LST)	Prevention Education
Media Ready	Environmental
Mentoring: Big Brothers/Big Sisters	Alternative Activities
Nurturing Parenting Programs	Prevention Education
PAL Peer Assistance and Leadership	Alternative Activities
Parenting Wisely	Prevention Education
Positive Action	Environmental
Project ALERT	Prevention Education
Project Northland	Prevention Education
Project SUCCESS	Prevention Education
Protecting You/Protecting Me	Prevention Education
Reward & Reminder	Environmental
Say It Straight	Prevention Education
Second Step	Prevention Education
SPORT	Prevention Education
Strengthening Families Program	Prevention Education
Strengthening Families Program: For Parents and Youth 10-14	Prevention Education
Strengthening Multi-Ethnic Families and Communities	Prevention Education

Compliance Review
DBHR uses the Prevention Services Site Review Checklist to ensure compliance with contract list and block grant requirements.

CHILDREN AND ADOLESCENT BEHAVIORAL HEALTH SERVICES

The Family Youth System Partner Roundtable (FYSPRT) provides leadership to influence the establishment and sustainability of Children's Behavioral Health System of Care (SOC) values and principles statewide. One of their primary responsibilities is statewide governance oversight of the SOC and the Recovery-Oriented Systems of Care (ROSCs) being developed in conjunction with State Adolescent Treatment Enhancement and Dissemination (SAT-ED). In collaboration with the SOC and SAT-ED Teams, the FYSPRT recommends strategies to provide behavioral health services and supports for children and youth as well as to monitor and review both process and outcome indicators. The FYSPRT supports and tracks the six goals of the Washington State SOC:

1. Infuse SOC values in all child-serving systems.
2. Expand and sustain effective leadership roles for families, youth, and system partners.
3. Establish an appropriate array of services and resources statewide, including home-and community-based services.
4. Develop and strengthen a workforce that will operationalize SOC values.
5. Build a strong data management system to inform decision-making and track outcomes.
6. Develop sustainable financing and align funding to ensure services are seamless for children, youth, and families.

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

- Legislative direction for the creation of Behavioral Health Organizations, starting with the integration of Mental Health and Substance Use Disorder in April 2016.
- Implementation of Wraparound with Intensive Services (WISe) emphasizes wraparound approach to both high level and other level need youth cases, adopting the Child and Adolescent Needs and Strengths (CANS) assessment tool to evaluate needs and strengths in multiple domains. Access to Care Standards highlights the need to evaluate functional need problems in all domains.
- As a part of our Washington Administrative Code (WAC) 388-877-0620 Clinical – Individual Service Plan outlines components required for 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.
  - Be in 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 the work of the CLIP Improvement Team and is strengthened by Systems of Care and TR Statewide, FYSPRT, and Executive Leadership Team (ELT) structures. The Statewide FYSPRT has participation from six youth serving state partners; Rehabilitation Administration (RA), Department of Health (DOH), Children's Administration (CA), Health Care Authority (HCA), Office of Superintendent of Public Instruction (OSPI), Developmental Disabilities Administration (DDA) and a tribal representative who works for RA.

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 RSN to further grow the workforce.

Beginning in July 2015, contractors are required to implement at least 60% Evidence-based Programs and/or Practices (EBPPs) into the RSN contracts for children/youth. It is expected to keep this same requirement as we move toward Behavioral Health Organizations by including the same language in the detailed plan.

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 EBP reporting, and multiple input methods for WISe system rollout, and CANs progress tracking
- Through our payment system (ProviderOne)
- Performance based contracting and contract monitoring
- Children's Behavioral Health Measures
- Through reports from TARGET the data system for SUD services; as well as outcome reports available through SCOPE

Washington state has identified various liaisons for children to assist schools in assuring identified children are connect with available mental health and/or substance use treatment, and recovery support services. All of these have been developed in coordination with 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, 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 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. SAPISP services include:

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

Treatment:
In two counties (one rural, one urban) a pilot project was developed to address co-occurring disorders for students in a school-based setting. This project has been communicated to OPSI and will focus on building capacity for the screening, assessment, referral, case management and treatment to students with co-occurring disorders. This project will enlist 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 will be best practices identified by the University of Washington Evidence Based Practice Institute. An integral component of this project is training school staff in Mental Health First Aid. This evidence-based program teaches individuals how to identify and respond to mental health and substance use risk factors and warning signs.

QUALITY IMPROVEMENT PLAN

DBHR has a long-standing commitment to continuous quality improvement to ensure the best possible service delivery to its clients. DBHR's quality management program

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

The 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:

- Consumers and consumer groups
- Staff from the Governor's Office
- Staff from the Office of Financial Management
- Staff from Research and Data Analysis
- Tribes
- Counties, RSNs, and Providers

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

PREGNANT WOMEN AND WOMEN WITH DEPENDENT CHILDREN

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

Agencies work to get pregnant women into services within 24 hours, if a residential placement is needed and not available interim services are provided. If residential

services are not needed they are enrolled in outpatient treatment. When services are not available, the provider is required to ensure the following:

- Provision of, or referral to, counseling on the effects of alcohol and drug use on the fetus.
- Referral to prenatal care.
- Provision of or referral to human immunodeficiency virus (HIV) and tuberculosis (TB) education.
- Referral for HIV or TB treatment services if necessary.

Behavioral Health Program Managers are contract managers for PPW Residential services while county coordinators are responsible to monitor outpatient and withdrawal management services. On-site monitoring takes place at least one time per biennium. A protocol for monitoring the contract is completed and placed in the contract file. Any findings are identified and presented to the program for changes to be made, including the corrective action plan and timeline. If the corrective action plan has not been met, then additional requirements may be placed. Utilization of funds/bed days is monitored on a monthly basis by the Contract Manager and Behavioral Health Treatment Manager. Certification is monitored one time every three years for compliance with certification requirements in WAC.

Residential

Our residential system is a statewide resource; patients are assisted with transportation needs in support of accessing treatment.

There are nine PPW residential providers. Pregnant and parenting women are given priority access to DBHR-funded treatment services. Residential Substance Use Disorder treatment is available for women and their children under the age of six.

Housing Support

There are eight PPW housing support programs. Recovery support and linkages to community-based services is provided in alcohol- and drug-free residences for women and their children.

- An initial needs assessment is coordinated with a treatment provider and the woman to determine current need for services.
- A care plan is developed with the woman to identify community supports to maximize her recovery plan. Case management is provided to monitor for substance abuse and participation in outpatient substance use disorder treatment, and to facilitate linkages and appointments for pre- and post-natal medical care, financial assistance, social services, vocational services, childcare needs, and permanent housing.

Outpatient

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

STATE BEHAVIORAL HEALTH ADVISORY COUNCIL (BHAC)

The Division of Behavioral Health and Recovery is committed to creating an effective partnership with consumers 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 consumers and stakeholders.

DBHR has capitalized on the history of consumer involvement and established an integrated Behavioral Health Advisory Council (BHAC) in 2012.

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

STATE BHAC MEMBERSHIP

Members	Representing
Armando Herrera	Community Member
Carmen Pacheco-Jones	Community Member
Carolyn Cox	Community Member
Eleanor Owen	Community Member
Elizabeth Andrews	Community Member
Heather Maxwell	Community Member
Jeff Adrich	Community Member
Jo Ellen Woodrow	Community Member
Kimberly Miller	Community Member
Kristina Sawyckyj-Moreland	Community Member
Linda Kehoe, Ed.D.	Community Member
Moira O'Crotty	Community Member
Myra Paull	Community Member
Norrie Gregoire	Community Member
Phillip Gonzales	Community Member
Sandra Koloske	Community Member
Susan Kydd	Community Member
Vanessa Lewis	Community Member
Becky Bates	Provider
Mary O'Brien	Provider

Annabelle Payne	Provider
Beth Dannhardt	Provider
Steve Kutz	IPAC Tribal Representative
Shelly Young	ACHS Chair
Mark Freedman	Regional Support Network
Barb Putnam	Children's Administration
Kathleen Arnold	Corrections
Monica Reeves	Developmental Disabilities
Tory Henderson	Health
Dan Halpin	Insurance Commissioner's Office
Pamala Sacks-Lawlar	Juvenile Rehabilitation
Kathy Morgan	Home/Community Services
Ron Hertel	Office of the Superintendent of Public Instruction
Kristin West	Problem Gambling
Vacant	Health Care Authority
Vacant	Vocational Rehabilitation

STATE BHAC COMPOSITION BY MEMBER TYPE

Current Membership			Full Membership Needed for SUD/MH Balance	
Type	**#**	**%**		
Total Community	20	56%	3	58%
In recovery-CD	4	11%	0	0%
In recovery-MH	4	11%	0	0%
In recovery -Both	2			
Family-CD	1	3%	1	3%
Family-MH	2	6%	0	0%
Family - Both	4			
Parent-CD	1	3%	0	0%
Parent-MH	1	3%	0	0%
Youth - CD	0	0%	1	3%
Youth - MH	0	0%	1	3%
General Public	1		0	0%
Total State/Provider	16	44%	1	3%
Leading State Experts	9	25%	1	3%
Tribal	1	3%	0	0%
Appointed (RSN,ACHS)	2	6%	0	0%
Provider - CD	1	3%	0	0%
Provider - MH	1	3%	0	0%
Provider -Both	2	6%	0	0%
Total	**36**		**40**	

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