

## ORGANIZATION OF THE BEHAVIORAL HEALTH SYSTEM

The Department of Social and Health Services (Department) include the majority of the Washington state's social and health programs. The Department's mission is to improve the safety and health of individuals, families and communities by providing leadership and establishing and participating in partnerships. The Department collaborates with the State Medicaid Authority (the Health Care Authority-HCA) through formal Memoranda of Understanding (MOUs) and interagency agreements. The Washington State Division of Behavioral Health and Recovery (DBHR), created in June 2009, by combining the mental health and substance abuse divisions. This division serves as the Director for the Single State Agency (SSA) and the State Mental Health Agency (SMHA) for the State of Washington. Chris Imhoff is the director of DBHR, and as such, serves as the director for SSA and SMHA. DBHR resides within the newly formed Behavioral Health and Service Integration Administration under Aging and Disability Services (ADS) which is part of the state's large social services agency, the Department of Social and Health Services.

DBHR funds a continuum of services to support prevention, early intervention, treatment and recovery support services for youth and adults with behavioral health needs. We prioritize services that meet the needs of the individual, family, and community. Within this service delivery continuum, Washington State leverages partnerships and local dollars to meet the broad behavioral health needs of its citizenry. DBHR funds prevention (including targeted prevention services, community-based environmental strategies, and behavioral health promotion strategies), works to create a broad system of treatment options, sponsors recovery supports, and champions the development of system of care networks.

The Revised Code of Washington (RCW) Chapter 70.96A identifies DBHR as the single state agency for planning and delivery of substance abuse prevention and treatment services. All public substance abuse services in Washington State funded by state or federal funds are either managed by DBHR or operated in coordination with DBHR (e.g. services provided by the Washington State Department of Health, Office of Superintendent of Public Instruction, Department Of Corrections, and Health Care Authority). DBHR provides oversight, including program policy and planning, program implementation, provider certification, fiscal and contract management, Management Information Systems (MIS) and comprehensive program outcome studies.

The Department, as designated in RCW 71.24.05, is the state mental health authority in developing the state mental health program for 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. All community mental health facilities in Washington State are supported by Medicaid, state, and/or block grant funds.

The public system implements the mental health crisis and involuntary treatment act for the citizens of the State. DBHR operates two adult state psychiatric hospitals: one is in western Washington and one in eastern Washington. A children’s psychiatric hospital is operated in western Washington immediately adjacent to the adult hospital. Within the adult hospitals, there are two systems of care: civil and forensic.

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.

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 organized around children/youth and adult services; **an overview of the continuum of care** offered by Washington State; **the behavioral health service providers**; and, 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.

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## CONTRACTING OF THE PUBLIC BEHAVIORAL HEALTH SYSTEM

### *Mental Health-Regional Support Networks*

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. In addition, 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.

RSNs receive Medicaid funding based on a per-member-per-month formula for disabled and non-disabled adults and children within their regions. State-only and block grant funding is allocated to RSNs based on their total population. State funding is used to operate the crisis and involuntary treatment systems, evaluation and treatment centers, and limited residential/outpatient services.

The block grant covers critical services for RSNs that are not covered by Medicaid or state direct funds: homeless services; housing assistance; crisis outreach; suicide prevention; consumer-operated programs such as mental health clubhouse services; help lines; and education, training and support for consumers and their families.

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.

#### *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.

#### *Chemical Dependency*

##### Counties

All outpatient treatment services for youth and adults is 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. DBHR also contracts for acute and sub-acute detoxification through counties.

##### Tribes

Chemical dependency funds are allocated to tribal chemical dependency programs of each of the 29 federally recognized tribes in Washington State to support the delivery of outpatient treatment services and community-based 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 Indian Health Services’ service area population figures. Tribal programs provide services mostly to the tribal populations, but can serve nontribal members as well.

##### Direct Contracting

DBHR contracts directly with state-certified chemical dependency for youth, adult, and pregnant parenting women residential treatment programs. Contracts include specific assessment and counseling requirements, staffing ratios, reporting and referral requirements. Treatment for family and significant others is included, as well as relapse and long-term recovery education and counseling.

##### Involuntary Treatment

The State contracts with secure, long-term residential programs to provide treatment for chemically dependent individuals who 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, Washington or Pioneer Center East in Spokane, Washington

##### 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. DBHR funds community prevention services through direct service contracts with Washington State's Office of Superintendent of Public Instruction, counties, and tribes. Most services provided are structured drug prevention curriculum for youth and parenting classes for adults. Services also include community-organizing efforts directed at substance abuse prevention, drug education campaigns, and drug-free activities.

DBHR contracts with the Office of the Superintendent of Public Instruction (OSPI) for the placement of 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 intervention specialists also make referrals to mental health and substance abuse treatment providers and support students' in their' transition back to school after they receive treatment.

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## **ADULT BEHAVIORAL HEALTH SYSTEM**

### *Chemical Dependency*

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 chemical dependency outpatient treatment services for adults 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. In order for adults to access Medicaid and other state funded services, the Department's Community Services Offices must first determine eligibility.

Intensive outpatient and outpatient treatment for chemical dependency 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.

Detoxification services assist patients' withdrawal from alcohol and other drugs. Acute detoxification occurs in a medical setting and provides medical care and physician supervision for withdrawal. Sub-acute detoxification 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 chemical dependency (CD) treatment for adults in the state. Intensive inpatient treatment provides a concentrated program, up to 30 days, 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 chemical dependency treatment receives a minimum of 20 hours of treatment services each week. Long-term treatment provides treatment up to 180 days 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 chemical dependency treatment receives a minimum of four hours of treatment per week. Recovery Houses provide personal care and treatment for up to 60 days, 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 chemical dependency treatment receives a minimum of five hours of treatment services per week.

Pregnant and parenting women (PPW) are given priority access to DBHR-funded chemical dependency treatment services. PPW Residential chemical dependency treatment lasting up to six months 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.

Medication-Assisted Treatment (MAT) is pharmacotherapy related to substance abuse. It combines pharmacological intervention with counseling and behavioral therapies. 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 in conjunction with state certified chemical dependency treatment. Medicaid payment authorization is also required for utilization of this type of treatment.

Opiate Substitution Treatment (OST) provides a combination of chemical dependency counseling along with adjunctive medication. OST 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 15 sites offering OST services.

Washington has codified statutes aimed at protecting individuals and the community by providing for involuntary chemical dependency 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 chemical dependency. RCW Chapter 70.96A.140 authorizes a designated chemical dependency specialist to investigate and

evaluate allegations that a person is incapacitated as a result of chemical dependency. 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 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 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*

Regional Support Networks (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 fee-for-service Medicaid services 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 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.

Voluntary and involuntary community inpatient services for adults are authorized by the RSNs and are provided in community hospital psychiatric units, community psychiatric hospitals 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.

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. These hospitals have 1093 beds between them.

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.

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## **CHILDREN’S BEHAVIORAL HEALTH SYSTEM**

### *Chemical Dependency*

Access to chemical dependency 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. Financial eligibility for Medicaid enrollment is determined by the Department’s Community Service Office. Treatment providers review parent income to determine admission eligibility for any state-funded program or a sliding fee scale. The age of consent for outpatient chemical dependency services is 13 years old and older. Youth may seek treatment services on their own. 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.

State certified outpatient programs generally provide chemical dependency 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 Chemical Dependency Services are composed of four modalities, including Detoxification and Crisis Stabilization services, Level I Intensive Inpatient, Level II Intensive Inpatient, and Recovery House programs.

The purpose of the Detoxification 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 participants in Level I Residential programs generally do not require intensive therapeutic intervention for other disorders, such as mental disorders or aggressive behavior, as part of primary chemical dependency treatment. Length of stay is variable and can be up to 60 days, based on clinical needs and program design.

Level II Youth Intensive Residential treatment is used for youth who are chemically dependent and have other issues requiring concurrent management with the treatment of addiction. This could include symptoms of a mental health diagnosis (e.g., attention deficit-hyperactivity disorder, depression, conduct disorder, etc.), extreme family dysfunction, and/or prior trauma due to emotional, physical, and/or sexual abuse. Length of stay is variable, with an expected range between 30-60 days, but may be extended up to 120 days. Level II programs are required to provide mental health specialist services and staff sufficient to respond to the security needs presented by youth who are at risk to leave treatment against clinical advice.

Youth appropriate for Recovery House services have completed residential chemical dependency treatment, and are transferred to a Recovery House when they cannot immediately live with their legal guardians, parents, foster parents, or 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 to 120 days.

Youth who may be experiencing immediate and life threatening consequences of chemical dependency, 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 chemical dependency 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 includes brief



intervention, crisis services, day support, family treatment, freestanding evaluation and treatment, individual and group treatment, high intensity treatment, medication management and monitoring, residential treatment, peer support, case management, stabilization services and therapeutic psycho-education.

There are two freestanding Evaluation and Treatment Centers providing involuntary treatment services for youth in Kitsap and Yakima Counties. 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 44 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 91 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 up to 20 sessions of mental health treatment per year with additional services available if needed.

### **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 four statewide conferences and trainings each year which are:

- Co-Occurring Disorders and Treatment Conference;
- Prevention Summit.
- Saying It Out Loud Conference.
- Behavioral Health Conference.

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.

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 2012, 46 youth teams attended leadership

workshops for developing and implementing prevention projects in their schools and communities.

The Saying it Out Loud Conference brings together professionals from the diverse fields of social work, mental health, chemical dependency treatment, and substance abuse prevention. It focuses on the impacts of chemical dependency in the Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) community, as well as current resources and research.

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

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 abuse, serious mental illness, and/or dual diagnoses. The co-location of mental health and chemical dependency/substance abuse treatment within a single division has been a significant strength as Washington State continues to prepare for Health Care Reform. Washington recognizes the importance of early intervention and the need for ready access to services. We would anticipate an increased availability of mobile crisis and stabilization that incorporates System of Care principles and enhanced home and community-based 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 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 need to reduce barriers and provide multiple avenues for individuals to travel on their road to wellness and recovery.

Washington State is one of the recipients of a planning grant for Health Information Technology (HIT), administered by the Health Care Authority (HCA). The responsibilities of HCA include planning for the development of the state's Health Information Exchange (HIE) and managing the purchase of Medicaid services for the state. It is expected that the HIE will eventually include behavioral health services as well as the current primary health care packages.

A significant concern is the need for consumers, stakeholders and even providers to better understand our behavioral health system. We need to better educate all interested parties about the services, the impacts, and the outcomes of our system. A second concern is the full integration of peers as integral players in behavioral health services. We would like to see more peers employed by the behavioral health agencies. A final concern is the lack of behavioral health services for youth in non-stigmatized settings (e.g., school-based or at the local community center). This includes the need for more services for transition age youth, such as independence and transitional living skills.

The most 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 chemical dependency "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 extending through our way of thinking to serving and providing services.

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## **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 Prevention Redesign Initiative (PRI) 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 awash in high rates of crime, poor school performance, and poor public health.

Previously, prevention services, although evidence-based, were not targeted. With limited resources, counties and the Office of the Superintendent of Public Instruction (OSPI) have attempted to reach as many communities as possible with some level of service, and in most cases, without leveraging each other’s resources. This resulted in communities not receiving an adequate amount of resources over time to realize community-level change.

PRI identifies and directs services to the highest need communities in each county. Components of the PRI 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 evidenced-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 illness 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. DBHR is currently participating in a Trauma-Informed Care training project that includes promotion of screening for Adverse Childhood Experiences by the Department employees and providers.

DBHR collaborates with other state agencies to address overall wellness. Examples include the Maternal, Infant and Early Childhood Home Visiting Program (MIECHV) (Department of Early Learning) and the Suicide Prevention program (Department of Health). Both of these programs include strategies for prevention of behavioral health risks and the increase of protective factors. The MIECHV funding allows Washington to expand services to at-risk families, provide supports for programs offering home visiting, and measure results achieved in key benchmark areas. An updated State Plan for Home Visiting (June 2011) identifies high-risk communities to receive funding for evidence-based home visiting programs, and outlines a plan for meeting legislatively-mandated benchmarks required by the federal legislation.

### **Early Intervention**

DBHR has supported early intervention collaborative projects with other child-serving agencies and partners (e.g., the Department’s Children’s Administration, community health and safety networks, 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 Department's 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). DBHR has secured a new grant to implement SBIRT in primary care clinics in King County. We expect to show that providing SBIRT services in primary care can save money and improve lives. This project will demonstrate the feasibility and efficacy of implementing SBIRT within primary care settings. This project will also influence the inclusion of SBIRT services in state contracted Medicaid Managed Care and other procurements in preparation for 2014 when another 250,000 to 300,000 individuals will be eligible for Medicaid under the Affordable Care Act.

### **Treatment**

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 RSNs 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. The list of covered diagnoses includes most mental illnesses. Examples of excluded diagnoses are those served by other mechanisms (e.g., pervasive developmental disorders are treated through the HCA and the Department's Division of Developmental Disabilities) or those that are deemed less severe. Non-covered diagnoses can be present when a primary diagnosis is covered.

Chemical dependency 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 chemical dependency services in local communities. If the consumer needs residential chemical dependency treatment, referral is made to Washington State's statewide residential treatment system.

Chemical dependency residential services are provided through direct contracts with providers. The residential system is statewide and treatment programs are developed to meet the needs of the population served - youth, pregnant and parenting woman, and

adults.

Several Evidence-Based Practice pilots have been initiated 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.

DBHR is a recipient of the State Adolescent Treatment Enhancement and Dissemination grant that will allow DBHR 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**

DBHR awarded the Seattle Crisis Clinic a performance-based contract to operate a new behavioral health recovery help line. This consolidated contract replaces three separate contracts with the Evergreen Council on Problem Gambling, the National Alliance for Mental Illness-Greater Seattle, and the Alcohol/Drug 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.

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, childcare, peer supports, and specialized programs. To deliver these services, it is critical to embed them within a system of care in which consumers can identify realistic goals, prioritize

the steps to meet goals, and select those services that will aid them on their path to recovery.

DBHR is committed to enhancing support services that are locally identified and community supported. To assist in identifying a framework to develop or expand local Recovery Oriented Systems of Care (ROSC), representatives from the Association of County Human Services (ACHS) and DBHR formed a ROSC workgroup. The workgroup is reviewing and recommending the most effective ways to develop local ROSC models throughout the state. This workgroup will expand to include other partners and align its work with other stakeholder processes. Currently, chemical dependency recovery support services exist in a disjointed manner, and we have identified this as a significant issue for the state.

Several grants (including the Access to Recovery (ATR) grant and a Drug Court Enhancement grant) provide 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, childcare, transportation, employment and housing assistance. The services provided through these grant programs are consumer driven, and self-directed, with consumers selecting from a menu of support services they believe are most critical in aiding them on their path to recovery. Over the past six years ATR has provided a broad array of recovery services to more than 12,000 consumers seeking recovery from misuse of drugs or alcohol. The program used a community outreach model (with over 60 community meetings) that emphasized consumer input for the local model and for personalized recovery plans. One result is that the State set aside some of the grant funding to serve US military personnel returning from Iraq or Afghanistan.

DBHR supports the efforts of over 235 Oxford Houses in Washington State (approximately 1,997 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 House 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, and the average stay is 12-24 months. Each house represents a remarkably effective and low cost method of preventing relapse. This was the purpose of the first Oxford House established in 1975. Oxford House, Inc. is a publicly supported, non-profit corporation. It is the umbrella organization connecting all Oxford Houses and allocating resources to duplicate the Oxford House model where needs arise. 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 abuse 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.

Alcohol- and drug-free residences are provided for women and their children for up to 18 months 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 chemical dependency 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. As an example, block grant funding was used to translate the training manual into Spanish. The Spanish language manual will be used to deliver peer training in Spanish this year.

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, and certified peer specialists, and peers from consumer operated services in Clark, King, North Sound, OptumHealth-Pierce, and Peninsula RSNs.

DBHR has contracted with four community peer groups for Family Network Capacity Building to increase family voice statewide in support of various ongoing mental health transformation projects with family leadership as a core constituency. These groups are the National Alliance on Mental Illness (NAMI), Passages Family Support, Sound Mental Health, and Washington PAVE. These groups will provide support and peer-to-peer mentoring to parents and caregivers of minor children challenged with behavioral health disorders.

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 Department's Children's Administration and Economic Services Administration, 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 for individuals with substance abuse or mental health problems who are involved with the criminal justice system. This includes Drug Court. 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.

DBHR funds and actively participates in programs designed to train and empower consumers (adults, families raising children with complex needs and youth). 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.

DBHR's Office of Consumer Partnership (OCP) 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's and adult mental health and chemical dependency. A youth member is soon to be added to OCP. 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.
- Strengthening consumer voice as a part of contracted provider services.
- 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.
- Supporting the development of and sustainable funding for recovery supports (e.g., housing, employment and transportation).
- Facilitating regular communication with the recovery community.
- Supporting the expansion of peer support services.
- Providing technical assistance to consumer and family operated organizations.
- Promoting anti-stigma education.

### **Strengths and Needs of Washington State's Continuum of Care**

DBHR has made progress in the behavioral health integration process, as illustrated by our expanded continuum of care for both mental health and substance abuse services. The current economic crisis and continuing uncertainty affects a growing range of individuals and families, including those who were previously able to manage with traditional community supports. DBHR continues to strengthen across systems links to improve services for individuals at risk of and/or experiencing mental health and substance abuse crises. We hope to address this need through a broad-based System of Care strategy that engages all of our state, local and community partners.

As a response to the challenges that have presented themselves through our recent changes to an integrated continuum of care, DBHR underwent a needs assessment and

prioritization exercise to identify areas of need within our system and set agency goals for behavioral health. The results of this effort were released in the issue paper **Adult Behavioral Health System – Making the Case for Change**. This issue paper offers an approach designed to move adult behavioral health to an outcome-based system that uses evidence-based and research-based practices. This application for funding is structured around meeting the goals identified in that document. Namely:

- Decrease population-level disparities
- Improve health and wellness status
- Improve satisfaction with quality of life
- Increase meaningful activities, including employment and education
- Increase stable housing in the community
- Reduce involvement with criminal justice systems, including jails and prisons
- Avoid costs in hospitals, emergency rooms, crisis services, and jail/prisons
- Enhance safety and access to treatment for forensic patients

Finally, there are 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.

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## **BEHAVIORAL HEALTH SERVICE PROVIDERS**

Until recently, licensing and certification processes and the Washington State Administrative Codes (WACs) that govern agencies were different for mental health and chemical dependency providers. Numerous providers were licensed/certified in both service areas. In 2011, DBHR initiated a comprehensive rule-making process to develop rules that govern all behavioral health treatment services.

These new rules are now in effect and establish a single set of administrative standards, while supporting the program specific requirements, for the licensing and certification of behavioral health agencies to provide chemical dependency, mental health, and problem and pathological gambling treatment. The new rules will reduce administrative burden and improve client care. For more information regarding the new behavioral health treatment services WACs, please visit:

<http://www.dshs.wa.gov/dbhr/stakeholders.shtml#dbhr>.

### **Prevention Providers**

Substance abuse prevention services are provided across the state. These efforts are largely funded by the 20 percent Substance Abuse Prevention Treatment (SAPT) block grant set-aside. As the SAPT funds are allocated to counties, it is up to the counties to either deliver or contract to deliver prevention services. Because of the wide range of services (from evidence-based curricula delivered in elementary schools to policy change initiatives at the county government level), the range of prevention service providers is equally diverse. DBHR collaborates with the Office of the Superintendent of Public Instruction (OSPI) to place prevention/early intervention services in some

schools. (With the reduction in state funding, the number of services provided is declining.)

Prevention/Intervention (P/I) Specialists, most of whom are chemical dependency professionals, identify youth who are at risk, provide school-based interventions, screening, and when called for, referral to services. In some school districts, treatment services are delivered on school property. For youth who are referred to treatment, there are recovery support services available in schools after treatment completion. Although suicide prevention is school-based, other services for the prevention of mental health problems are not included in our system of care. However, the P/I specialists operating in the schools identify and screen youth they recognize as having mental health problems, and refer them to mental health treatment services when necessary. The following counties and educational service districts (ESDs) are currently participating in PRI efforts:

**Cohort 1 Counties:** Adams, Benton, Chelan, Clark, Jefferson, King, Pacific, Okanogan, Pierce, Snohomish, Thurston, Whatcom, and Yakima.

**Cohort 2 Counties:** Asotin, Clallam, Columbia, Cowlitz, Grant, Island, Kitsap, Kittitas, King, Lincoln, Skamania, and Spokane.

**Cohort 3 Counties for FFY2014:** Benton, Douglas, Ferry, Garfield, Grays harbor, King, Kitsap, Klickitat, Lewis, Mason, Pend Oreille, Pierce, Skagit, Spokane, Stevens, Walla Walla and Wahkiakum.

**ESDs:** 101 (Spokane), 105 (Yakima), 112 (Vancouver), 113 (Olympia), 114 (Bremerton), 121 (Renton), 123 (Pasco), 171 (Wenatchee), and 189 (Anacortes).

### **Mental Health Treatment Providers**

Washington State's Medicaid program through Health Care Authority offers a limited mental health medical benefit of 12 visits for adults and 20 visits for children. This benefit is intended for those with mild to moderate mental health problems. Adults and children who meet access to care standards receive a comprehensive benefit through the RSN.

DBHR oversees the public mental health system, which consists of 11 Regional Support Networks (RSNs). Each RSN provides services within one or more counties. The RSNs contract with providers primarily community mental health agencies (CMHAs). RSN providers also include freestanding Evaluation and Treatment centers (including ones specifically for youth), crisis triage facilities, residential facilities and housing resources. RSNs are responsible for authorizing voluntary admissions or involuntary commitments to community hospitals. Two state psychiatric hospitals—Western State Hospital and Eastern State Hospital—serve adults. In state fiscal year 2012, 139,041 adult and youth consumers received either inpatient and/or outpatient mental health services.

In conjunction with the American Indian Health Commission and the Office of Indian

Policy, DBHR drafted a set of guidelines for an attestation process so tribal mental health providers can attest to meeting the requirements for licensure as Community Mental Health Agencies. This process allows tribal mental health providers and the state to comply with the Medicaid State Plan for Rehabilitative Services and related CMS requirements.

### **Chemical Dependency Treatment Providers**

DBHR is the single state agency (SSA) that oversees publicly-funded CD treatment in Washington State. DBHR contracts directly with community-based residential treatment providers and tribes, while the counties contract with community-based outpatient and opiate treatment providers. Tribal programs, as direct contractors, have the flexibility to determine the local needs and choose to fund prevention services, treatment, or a combination of the two to best meet their needs.

Several treatment agencies offer programs designed for pregnant and parenting women (PPW) and consumers with co-occurring disorders (COD). Some educational school districts (ESDs) offer school-based, youth outpatient treatment programs. Treatment agencies may offer multiple programs in a single or multiple sites.

### **Recovery Support**

In conjunction with the Access to Recovery and Adult Drug Court Enhancement grants, Washington State provides Recovery Support Services (RSS) to consumers seeking recovery from alcohol or substance misuse in nine counties. Recovery support providers are community- and faith-based and grounded in their local community. There are currently 190 recovery support providers who have agreements with the nine counties where we offer RSS.

### **Hospitals**

Eastern State and Western State Hospitals are the two state-operated adult psychiatric hospitals for individuals requiring treatment for longer periods than community hospitals and E&Ts are able to provide. Approximately 70 percent of individuals at the state hospitals are under civil commitment orders. The remaining 30 percent are receiving court-ordered forensic services. Long-term inpatient treatment services for children are provided at the Child Study and Treatment Center (CSTC), an inpatient children's psychiatric hospital located on the grounds of Western State Hospital. There are four Children's Long-term Inpatient Programs (CLIPs) that provide care for children and youth, including CSTC and three non-profit Psychiatric Residential Treatment Facilities (PRTFs) with 91 beds total. Treatment is regulated under 42 CFR 441.150.

### **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 in

2014, 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. This results in many individuals being “boarded” in emergency rooms and hospitals that are not fully equipped to meet their mental health needs.

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 are two critical needs for the behavioral health providers in Washington. First, there is the need to have services more integrated across systems. Specifically we need to allow for treatments for both chemical dependency and mental illness, as well as to integrate bi-directionally with primary care without losing necessary specialty services. Equally important, the providers and networks need assistance in developing the capacity and tools necessary for the full implementation of the Affordable Care Act and Health Reform.

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## **THE SYSTEM ADDRESSES THE NEEDS OF UNDER-SERVED POPULATIONS**

### **Addressing the Needs of Racial, Ethnic and Sexual Minorities**

In 2009, DBHR sent a team of seven individuals to participate in a SAMHSA sponsored national policy summit to eliminate disparities. The team produced a four point disparity initiative. That has resulted thus far in three phases of Policy Summit Initiative implementation. Phase 1 included a national literature review of methods to eliminate

disparities and statewide interviews with key informants to inform work being done in Washington. Phase 2 created a working definition of cultural competence based on the policy of comparable access to services and comparable outcomes across numerous sub-populations. It also created a model to examine data for potential disparities and a method to assess current system capacity for the provision of specialized services. Together a foundation was formed to assist DBHR and RSNs to identify strategies to close gaps. Phase 3 tested the model and supported the emergence of a learning community among the members of the Diversity Initiative Workgroup and RSN staff members charged with examining disparities. The next phase will provide additional collaboration with RSNs and technical support as they put in place strategies being created from examining data and service capacity to address disparities. The project also will document further “case studies” illustrative of the efforts and results of RSNs as they use the model created by the workgroup. DBHR is anticipated to put in place contract terms for RSNs to identify one or more disparities to be addressed in the coming biennium. This may result in WAC changes and/or additional contract requirements for RSNs.

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. One highlight from the 2010 plan was the development of Native American Specialist curriculum to reflect the needs of mental health professionals working with Native American populations. 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 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 chemical dependency 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.

DBHR also funds the Saying It Out Loud Conference with block grant funding. This conference is an opportunity to inform and provide updates on issues affecting the GLBTQ community. This conference brings together professionals from the diverse fields of social work, mental health, chemical dependency treatment, and substance abuse prevention to focus on behavioral health issues affecting the GLBTQ community. This conference provides current resources and research on issues related to the GLBTQ community.

#### **Addressing the Needs of Under-served Youth (Youth in Transition/Young Adults)**

Passing from adolescence into adulthood is a challenging time for everyone. These transition years can be even more trying for those who experience emotional and behavioral difficulties. The goal of interventions for youth in this target population is to assist them in making a successful transition into adulthood. This focus could include those attending a university, those with alternative lifestyles, and those in home schooling or in private schools.

In 2007, the Mental Health Transformation Grant identified youth-in-transition as an area where work still needed to be done. Through the support of the Transformation Project and the leadership of the Department (with support from the Children's Administration, Juvenile Rehabilitation Administration, and DBHR), a Youth in Transition (YIT) Work Group was formed. One task of this workgroup was to identify and recommend policies that would promote services and supports for youth with special needs, including substance abuse and mental illness. This includes youth who are at risk, in transition and/or bridging to adulthood. In 2010, the YIT workgroup merged with the Integrated Case Management (ICM) project as both groups were based in System of Care principles and many of the outcomes were shared. Additional outcomes from the YIT Collaboration resulted in identification and recommendations to reduce barriers for services, embed wraparound principles into the infrastructure, and developed and implemented a Trauma Informed Care Training for the Department. We expect this work to continue.

Integrated Case Management (ICM) is a multi-system infrastructure that guides the process of coordinating services for vulnerable youth and adults with complex needs and their families who are served in multiple systems. There are several ICM efforts



underway; each of these efforts involves collaboration between DBHR and other systems. The Secretary of the Department appoints the executive team and expects the team to provide governance for the ICM project. The steering committee provides support and resources for the implementation sites in four geographic areas: Skagit, Thurston, Pierce, and Okanogan counties. These projects involve teams from multiple systems that serve the same consumer or family, with an emphasis on wraparound principles. The goals are:

- Youth and families will achieve: health and wellness, safe and stable housing, job readiness and stable employment, life skills, education attendance and completion, safe and stable in-home care, seamless transitions from out-of-home placements, stable and safe families, and safe healthy communities to include natural supports.
- Our system will: remove barriers that inhibit services, maximize funding through shared resources, streamline services to create efficiencies that reduce duplication of work and services and seamless case management to provide holistic care for youth and families.

**Strengths and Needs of the State’s Approach to Under-served Populations**

DBHR is active in the Harassment, Intimidation and Bullying Workgroup led by the Office of Superintendent of Public Instruction. This workgroup, established by 2011 legislation, is tasked with developing strategies and identifying best practices for school instruction about mental health, youth suicide prevention and prevention of bullying and harassment. 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 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 chemical dependency, 32 percent and 11 percent, respectively.

The former Older Adult Treatment and Services subcommittee of the Mental Health Policy Advisory Council (MHPAC) dedicated its time to identifying the barriers and disparities related to older adult mental health services, evaluating programming proposals, and use its expertise to offer statewide conferences. Some communities in Washington state offer mental health EBPs serving older adults, such as the PEARLS and Gatekeeper programs but services for older adults with substance use problems are extremely limited. The move to integrate behavioral health and primary care creates a significant opportunity to improve service for older adults.

There continues to be a need to address stigma and discrimination against those with behavioral health issues. In addition, there is awareness that mental illness and substance dependence problem/ issues become evident in a variety of settings where

appropriate assistance and support is not readily available. We need to work at improving awareness of these issues and providing resources to address them.

The most critical need for the state's approach toward under-served populations is the lack of data to capture some of these needs. Specifically, more detailed information on necessary recovery support and family services is essential to expand recovery-oriented support and ICM. The early identification of behavioral health problems in medical and school settings and the development of screening, referral, and outreach protocols is critical. 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.

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## **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 started to implement Performance Based Contracting with the intent to continue to improve the individual's and family's experience of care and the quality of services.

Washington continues to emphasize data driven decision-making, including assessment, care coordination, and service implementation. A close collaborator of DBHR, the Research and Data Analysis (RDA) Division of the Department, 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 chemical dependency treatment services through the Treatment and Assessment Report Generation Tool (TARGET).

A number of SAMHSA Strategic Initiatives are currently being addressed, including the prevention of substance abuse and mental illness as described above, trauma and

justice, (drug courts, trauma-informed care, trauma-focused cognitive behavioral therapy), military families (Access to Recovery), and recovery support through the Office of Consumer Partnerships. DBHR staff participate in workgroups and on-going development of Health Homes in Washington State.

The Washington State Legislature has provided leadership and support in furthering health care reform efforts. Most recently, the Joint Legislative Select Committee on Health Reform Implementation was created in 2010 to provide a forum for policy discussions related to implementation of the Affordable Care Act in Washington State. During the 2011 Session, the Legislature authorized the Joint Select Committee to continue through 2014.

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**NEEDS ASSESSMENT: DATA-INFORMED DECISION MAKING**

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. It also assisted in the development of substance abuse treatment funding formula and allocation formula of the state psychiatric hospital beds.

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. It will suggest criteria and provide data for future funding allocation updates. These criteria will be presented to the 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. The survey, supported by five state agencies and administered every two years in over 80 percent of the state's public schools, are 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 2012 will provide data for DBHR's needs assessment this year.

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 **Behavioral Risk Factor Surveillance System (BRFSS)**. NSDUH will be used to estimate and monitor the prevalence rates for different types of substances and BRFSS will provide 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 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.

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 the reduction of underage drinking strategies at the individual, community, and local system level. In addition to HYS, the **Community Outcomes and Risk Evaluation Geographic Information System (CORE GIS)** will be used in community level needs assessment. The CORE GIS, developed as a set of social indicators that were 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, the Department of Social and Health Services, the Uniform Crime Report, and the Office of the Superintendent of Public Instruction.

Individual level services records allow 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 will provide information on provided by agencies throughout the state. Target provides information reported by agencies throughout the state. The **Consumer Information System (CIS)** collects and makes available data on mental health services provided by Regional Support Networks (RSNs) and their subcontractors as well as services provided at the state hospitals. The **Provider One** system contains medical billing and encounter data for Medicaid clients. We will use these data systems to evaluate utilization patterns, penetration rates, treatment profiles, and provider 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. 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 upon a data-driven process. On-going epidemiological analyses have already informed current funding allocation formula. We are developing new criteria that integrate more up-to-date and reliable data using more refined methodologies.

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 will provide data for ongoing monitoring of indicators selected by the SPE to inform any adjustment to the plan.

Under the state's Prevention Redesign Initiative (PRI), prevention funding is distributed to communities with the highest needs. Highest need communities are identified by the SEOW based on a risk ranking integrating prevalence and other social indicators. The risk rankings will be updated periodically by the SEOW.

County funding formula for chemical dependency treatment is also being refined to better align with data-based needs assessment outcomes. The DBHR Funding Allocation Workgroup was convened to review data and discuss allocation strategies. The proposed funding allocation factors were presented to the Association of County Human Services (ACHS)/DBHR liaison meetings. In addition to synthetically estimated rates of treatment needs by county, we are evaluating other factors (e.g. utilization patterns, penetration and retention rates, separate allocation for evidence-based practices). Integrating these factors ensures that we maintain focus on priority populations, full continuum of care, and retain commitment to youth treatment and evidence-based practices.

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 updated prevalence rates of serious mental illnesses, prior utilization rates, and average waitlist in recent years. The data were reviewed at the Regional Support Networks (RSNs) meeting. The mental health service needs assessment reviewed data regarding treatment needs, treatment disparities, and relevant outcomes (e.g. housing, employment, and education). The assessment identified needs unique to youth, adults, and older adults. Resource allocation will target services to address these unique needs with a specific emphasis on evidence-based practices.

### **Priorities Identified Based on Needs Assessment**

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 and anxiety have been identified as important areas, and suicide prevention is essential to mental health promotion. However, 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. Our needs assessment identified housing, employment, and education as priority areas for recovery services. We are committed to using evidence-based practices to address these needs.

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## CONSULTATION WITH TRIBES

Washington State Department of Social and Health Services established our 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 6 Recognized American Indian Organizations in Washington State. Once developed, these protocols were signed by the Governor, Department Secretary and tribal chairs in June 2006. These protocols are:

**Consultation Protocol:** Between 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 with the purpose to provide an opportunity for an exchange of information and opinion prior to a decision.

Consultation may be for the following reasons:

- Matters with statewide implications
- Proposed change to policy that has an impact to the tribes or RAIO
- Fund distribution
- At the request of a tribe
- At the request of IPAC

Consultation will be called at the highest level of the department:

- Secretary, deputy secretary or assistant secretary.
- The Department will send a minimum of two written notifications.
  - The first one within 45-60 days prior to the consultation
  - The second one within 15-30 days prior to the consultation
- The Department will email IPAC Delegates:
  - Participation notification
  - Follow-up notification
  - Minutes

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, IPSS, tribes and RAIO in accordance to these written directions.

- Roundtable meeting between tribal/RAIO and state administrations:
  - These meetings are designed to be with the administrations of the groups in advance to determine the scope of the situation and establish a work plan.



- Workgroup meeting between tribal/RAIO and state technical team:
  - Will provide the opportunity for technical teams from the state and tribes to address any technical challenges or barriers.
  - Work collaboratively on development of technical solutions.

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 January 18, 2013 announcing two scheduled roundtable meetings, and a consultation meeting on March 5, 2013 between the secretary of the Department and tribal leaders. The natural conduit for ongoing communications is the 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, the Indian Policy Advisory Committee, the American Indian Health Commission and the North West Portland Area Indian Health Board. The work group meets at least twice per month. Given that these are foci of the future, we expect to learn from the tribes during these meetings, as well as to look for much needed financial assistance through our block grant.

DBHR is a member of Aging and Disabilities Services [ADS] subcommittee of IPAC. Meetings are held monthly and typically review policy concerns, identify operational problems, identify problems and solutions and resolve any issues that surface. 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 the Indian Policy Advisory Council assist DBHR in reaching out to tribal members to be seated on each advisory council.

DBHR is committed to having two tribal representatives (from IPAC and the American Indian Health Commission) as members of the Behavioral Health Advisory Council and the Prevention Policy Consortium.

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**PUBLIC COMMENT ON THE STATE PLAN****Tribes**

DBHR leadership engaged in the government-to-government formal consultation process with leadership from Washington's 29 federally recognized tribes. Following the Department of Social and Health Services' protocol, there were two roundtable meetings regarding the block grant and a formal consultation. From this consultation process, we have included the tribes' perspectives in this application.

**Stakeholders**

The Division of Behavioral Health and Recovery (DBHR) worked collaboratively with its stakeholders (mental health consumers, chemical dependency consumers; counties, Regional Support Networks (RSNs), the Community Mental Health Council, chemical dependency organizations, provider associations, problem gambling service agencies, and the public to ensure all voices are heard in the development of the application. DBHR is using a variety of forums including face-to-face meetings, video/phone conferences, Webinars, and an active website. DBHR leadership met with RSNs, the Association of County Human Services, state agency partners (provider associations), tribes, and the Behavioral Health Advisory Council to present information on the Unified Block Grant application process and to collect input/ feedback on the needs assessment and proposed plan.

**Consumers**

Consumer voices are an important part of the application and the plan for ongoing federal funding. To ensure we included consumer feedback DBHR conducted two statewide Webinars: January 25, 2013, was to review the findings of the statewide needs assessment, and February 23, 2013, the proposed plan to meet the identified needs and gaps was shared. Both webinars were well attended, 62 and 70 people respectively, attended. As we continue to clarify the plan across the next 24 months, the public will continue to be offered similar avenues to have input.

**Compilation**

Compilation of feedback received from these different partner populations has been integrated to ensure that the application and plan is reflective of those we serve and available to the public through the DBHR website. The feedback process has been invaluable and will assist us in ensuring our plan becomes a living document for our division and for the state behavioral health system of care.

## **STATE BEHAVIORAL HEALTH ADVISORY COUNCIL**

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 stake holders.

Prior to being combined into the Division of Behavioral health and Recovery the Mental Health Division and Division of Alcohol and Substance Abuse (DASA) each had rich histories of consumer involvement and were viewed as national leaders in giving voice to consumers in addressing their needs. DBHR has capitalized on the direction provided in the new federal Community Mental Health Services and the Substance Abuse Prevention and Treatment block grant applications to develop a Combined Block Grant Application. The application guidelines encourage the establishment of an integrated Behavioral Health Advisory Council (BHAC). The Washington State Behavioral Health Advisory Council was formed in 2012.

It is the division's intent that the BHAC would be a policy partner with DBHR. As such, the BHAC 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 new council will continue to meet the 51 percent consumer requirement, with an added goal of maintaining equal representation with the mental health and chemical dependency consumers. Representatives from other state agencies, counties, tribes, Regional Support Networks, and providers are all active participants in the council.

There has been significant and unprecedented review and input from mental health and substance abuse consumer communities and from the community at large. Draft versions of the application have been posted on-line for public access and review.

The membership has made a commitment to be a working membership. As such, it will not have standing committees but rather use meetings for the purpose of addressing present issues and preparing recommendations for the division to consider.

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**PRIORITY AREAS AND ANNUAL PERFORMANCE INDICATORS**

**Behavioral Health Outcomes**

DBHR is committed to moving the Washington State behavioral health system toward meaningful outcomes and addressing disparities at the service provision level. This information is detailed in our issue paper entitled “Adult Behavioral Health System-Making the Case for Change” (November 29, 2012). Given the impacts of behavioral health disorders on multiple systems, it is imperative that outcomes strive to:

- Improve health status and wellness.
- Increase meaningful activities, including employment and education.
- Reduce involvement with criminal justice systems, including jails and prisons.
- Reduce avoidable costs in hospitals, emergency rooms, crisis services, and jails/prisons.
- Increase stable housing in the community.
- Improve satisfaction with quality of life, including measures of recovery and resilience.
- Decrease population-level disparities.
- Enhance safety and access to treatment for forensic patients.

Strategies for Mental Health Promotion, Substance Abuse Prevention, Mental Health Services, and Substance Abuse Treatment (including priority populations, adults, older adults, youth, and transitional age youth) are aligned to the Behavioral Health Outcomes as identified in the statewide needs assessment.

***Substance Abuse Prevention Strategies***

1. Community-level primary prevention services (PRI)

The Department’s Division of Behavioral Health and Recovery (DBHR) is committed to a statewide prevention system that is substantial and effective enough to achieve significant reduction in rates and impact of substance abuse statewide. We will contract with county governments and the Office of the Superintendent of Public Instruction (OSPI) to provide effective community-based prevention services to reduce alcohol, tobacco and other drug use by our state's youth, and the related problem behaviors. We anticipate that moving to a community-focused approach, with the expertise and commitment of our state and community partners will help us leverage resources and focus and concentrate our efforts. This will help Washington's prevention field build on what works, have a deeper impact, better measure those impacts, and build support for additional investments in prevention.

Community prevention efforts are to be implemented following the SPF model. Several contractual expectations are built in to ensure compliance with this model. At least 60 percent of recurring prevention programs will be evidence-based (Research Based). Communities will have an active coalition comprised of at least 8 of the 12 DFC sectors. The coalition will be staffed by a coordinator (.5

FTE minimum). The coalition will have a strategic and implementation plan approved and monitored by DBHR.

Community selection was based on county review of needs assessment data provided by DBHR which ranked communities on several indicators. By funding services in the highest needs communities within each county we increase the likelihood that prevention services are directed to traditionally underserved racial and ethnic minority populations. DBHR continues its commitment to supporting the discretion of Federally Recognized Tribes to spend Block Grant funding on CD Treatment, SA Prevention, or a combination these best meets their needs.

Short-term progress will be measured through the statewide distribution of communities working with county governments and OSPI educational service districts; establishing performance based contracts; Workforce Development; Providing effective Technical Assistance; and Preparing for Health Care Reform. Long-term success will be assessed through behavioral health outcomes for Children/Youth at Risk for BH Disorder as measured by community-level change in underage drinking, school drop-out, and suicide.

2. School-based prevention and early intervention services (OSPI/PISP)

DBHR will continue to contract with OSPI for school-based primary prevention and early intervention services for adolescents with substance abuse and/or mental health problems and Youth at Risk for BH Disorder. In order to align with the community-based prevention services funded through the counties, intervention services will be directed to those schools within the selected PRI communities.

Primary prevention services include student education and staff training as a universal strategy. Youth who present with a behavioral health related issue as a result of a disciplinary referral or through self-reporting will be screened by a school Prevention/Intervention specialist as a means of problem identification for referral to treatment if indicated. Ongoing services with these indicated students will be provided to keep them engaged in school and reduce school drop-out and improve academic results.

3. Statewide interagency planning (SPE Prevention Plan)

DBHR will continue interagency collaboration initially with the Prevention Policy Consortium funded through the State Prevention Enhancement (SPE) award to develop a coordinated approach for substance abuse prevention efforts across state agencies. The work of this group will be to continue implementation and adoption of the State Plan on Substance Abuse Prevention, which prioritized alcohol, marijuana, and tobacco.

4. Prevention services targeting young adults (College Coalition)

Students in college benefit from the coordination of activities, training, and lessons learned across campuses resulting in a more effective set of services

being offered. The College Coalition is focused on providing training opportunities on effective programs to reduce substance use. Trainings are offered throughout the year on a range of topics to address emerging trends or reinforce basic skills

5. Maintain a commitment to providing effective prevention strategies.  
Prevention contractors will use research-based, evidence-based, and promising practices for effective prevention strategies when they are available and culturally appropriate to the population being served. DBHR will specify a contractual obligation that at least 60 percent of recurring prevention programs in Prevention Redesign communities are evidence-based, research-based, or promising approaches.
  
6. Continue support for Federally Recognized Tribes to allocate funds to Prevention, Treatment, or a combination of the two based on local needs and prioritization.  
Block Grant funds to tribes are allocated to prevention and/or treatment services based on local needs. For tribes choosing to fund prevention services, DBHR will provide technical assistance for planning, implementation, and evaluation upon request. DBHR will also ensure that the Prevention MIS (PBPS) is able to collect and report on all SAP measures and that tribes have login access to the PBPS.

*Expected Measurement/Outcome*

First-year target/outcome measurement (Progress to end of SFY 2014):

1. Community-level primary prevention services (PRI): All community coalitions will report active participation at regular coalition meetings at least 8 of the 12 DFC sectors.
2. School-based prevention and early intervention services (OSPI/PISP): At least half of participants in recurring services will show improvement between pre- and post-tests.
3. Statewide interagency planning (SPE Prevention Plan): Maintain regular participation by members.
4. Prevention services targeting young adults (College Coalition): A minimum of four trainings will be provided annually.
5. At least 60 percent of recurring prevention programs in Prevention Redesign communities will be evidence-based, research-based, or promising practices.
6. Language in the Consolidated Tribal contract will reflect the flexibility of tribes to allocate SAPT Block Grant funding for prevention services in addition to treatment or to fund prevention or treatment exclusively.

Second-year target/outcome measurement (Final to end of SFY 2015):

1. Community-level primary prevention services (PRI): All community coalitions will report active participation at regular coalition meetings at least 8 of the 12 DFC sectors.

2. School-based prevention and early intervention services (OSPI/PISP): At least half of participants in recurring services will show improvement between pre- and post-tests.
3. Statewide interagency planning (SPE Prevention Plan): Maintain regular participation by members.
4. Prevention services targeting young adults (College Coalition): A minimum of four trainings will be provided annually.
5. At least 60 percent of recurring prevention programs in Prevention Redesign communities will be evidence-based, research-based, or promising practices.
6. Language in the Consolidated Tribal contract will reflect the flexibility of tribes to allocate SAPT Block Grant funding for prevention services in addition to treatment or to fund prevention or treatment exclusively.

***Substance Abuse Treatment – Youth Strategies***

1. Refer and place adolescents according to the American Society of Addiction Medicine (ASAM) criteria.  
 Washington State strives to provide a continuum of care for adolescent substance use disorder (SUD) treatment. The service range includes outreach and engagement services, screening, assessment, outpatient, intensive outpatient, detoxification services, intensive inpatient and recovery house residential services. Medication Assisted Treatment (Suboxone) is available for Medicaid funded youth 16 years and older if they meet all established requirements. Providing adolescents continuum of care services and supports that match their medical and recovery needs is optimal for creating access to required care and assists with improved health and wellness status.
  
2. Retain focus on federal and state mandated priority populations.  
 Priority is given to youth who have the most severe clinical needs. Clinical priorities include pregnant and parenting females, pregnant females who are Intravenous Drug Users, other intravenous drug users, those with or at risk for HIV, and those with or at risk for TB.
  
3. Maintain commitment to performance based contracting for provider and county contracts.  
 Identification and monitoring of performance measures for adolescent treatment services will assist in the improvement of services, maintaining quality of care and care management, and the likelihood of improved health and wellness outcomes for youth.
  
4. Increase commitment to evidence-based practices (EBPs), research-based, and promising practices available for adolescents with Substance Use Disorder (SUD). This strategy addresses quality of care practices and will assist with overall improved health and wellness status.

*Expected Outcomes/Measures*

First-year target/outcome measurement (Progress to end of SFY 2014):

1. At least 90 percent of funding will be used in each identified service category- outpatient, detoxification and residential treatment.
2. Less than 10 percent of contracts will receive a corrective action plan related to Priority Populations.
3. Counties and providers will reach or maintain their individual Performance-Based Contracting goals for SFY2014.
4. Baseline reports for evidence based and research based programs or practices will be created.

Second-year target/outcome measurement (Final to end of SFY 2015):

1. Increase EBPs, research based, or promising practices by 5% statewide.



2. No more than 5 percent of contracts will receive corrective action plans related to Priority Populations.
3. Counties and providers will reach or maintain their individual Performance Based contracting goal for SFY2015.
4. Availability of EBPs and research based programs will increase by 3 percent statewide.

**Substance Abuse Treatment – Young Adult Strategies**

1. Maintain commitment to a statewide continuum of care to refer and place young adults (18-24) according to the American Society of Addiction Medicine (ASAM) criteria.

Washington State strives to provide a continuum of care for substance use disorder (SUD) treatment. The service range includes screening, assessment, outpatient, intensive outpatient, detoxification services, and residential treatment services. Medication Assist Treatment is available for young adults if they meet all established requirements. Providing young adults a continuum of care services and supports that match their medical and recovery need is optimal for creating access to required care and assists with improved health and wellness status.

2. Retain focus on federal and state mandated priority populations.

Priority is given to young adults who have the most severe clinical needs. Clinical priorities include pregnant females who are IVDU, pregnant females, other intravenous drug users, parenting females, those with or at risk for HIV, and those with or at risk for TB.

3. Maintain commitment to performance-based contracting for provider and county contracts.

Identification and monitoring of performance measures for treatment services will assist in the improvement of services, maintaining quality of care and care management, and likelihood of improved health and wellness outcomes.

4. Increase commitment to evidence-based practices (EBPs), research-based, and promising practices available for young adults (18-24) with Substance Use Disorder (SUD). This strategy addresses quality of care practice and will assist with overall improved health and wellness status.

*Expected Outcomes/Measures*

First-year target/outcome measurement (Progress to end of SFY 2014):

1. At least 90 percent of funds will be used in each identified service category-outpatient, detoxification and residential treatment.
2. Less than 10 percent of contracts will receive a corrective action plan related to Priority Populations.
3. Counties and providers will reach or maintain their individual Performance-Based Contracting goals for SFY2014.
4. Create baseline report for evidence based and research based programs or practices provided to young adults.

Second-year target/outcome measurement (Final to end of SFY 2015):

1. 95 percent of funds will be utilized in each identified service category.
2. Less than 5 percent of contracts will receive corrective action plans related to Priority Populations.
3. Counties and providers will reach or maintain their individual Performance Based Contracting goal for SFY2015.
4. Availability of EBPs and research based programs will increase by 3 percent statewide.

***Substance Abuse Treatment – Pregnant Women and Parenting Women (PPW) Strategies***

1. Chemically dependent pregnant and parenting women (PPW) across Washington State will continue to receive priority admission into the continuum of chemical dependency treatment services. The ability to access these services in a timely manner reduces costs and supports improved health for the women and their children.
2. Counties and tribal programs will provide interim services and referral for prenatal care for women awaiting an appropriate treatment admission. These interim services help the state in avoiding additional costs due to lack of services.

*Expected Outcomes/Measures*

**First-year target/outcome measurement (Progress to end of SFY 2014):**

1. At least 95 percent of the residential providers will ensure that PPW receive priority admission.
2. Review strategies and make recommendations for reporting on Interim Services; including types and length of time receiving service.

**Second-year target/outcome measurement (Final to end of SFY 2015):**

1. PPW will receive priority admission at all residential providers.
2. Develop a plan for reporting on interim services.

***Substance Abuse Treatment – Intravenous Drug User Strategies***

1. Intravenous Drug Users (IVDU) across Washington State will continue to receive preference for admission to treatment facilities and outreach services.
2. Assist state contracted facilities when they fall below 90 percent capacity level.
3. Interim services will be provided when state contracted treatment services are not immediately available for Intravenous Drug Users.

*Expected Outcomes/Measures*

First-year target/outcome measurement (Progress to end of SFY 2014):

1. At least 50 percent of treatment providers will be in compliance with IVDU block grant requirements.
2. At least 90 percent of treatment providers who fall below 90 percent of their capacity will submit written notification to DBHR.
3. At least 90 percent of Intravenous Drug Users will receive interim services until they are admitted into treatment

Second-year target/outcome measurement (Final to end of SFY 2015):

1. Treatment provider compliance with IVDU requirements will increase 10 percent from the previous year.
2. All treatment providers who fall below 90 percent of their capacity to admit IVDU will submit written notification to DBHR.
3. Intravenous Drug Users who receive interim services until they are admitted into treatment will increase 5% from the previous year.

***Substance Abuse Treatment – Tuberculosis Strategies***

Certified CD providers are required to use The Centers for Disease Control Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health-Care Settings, 2005, to evaluate risk levels and implement screening and control measures consistent with the level of risk for the setting.

Currently required by Washington Administrative Code 388-805-325(9) accurate screening will identify those persons at risk for or in possibly contagious state for referral to other services. Requiring screening of all patients eliminates disparity of service. The use of the CDC Guidelines ensures methods are consistent with accepted national standards for evaluating risk and referral to appropriate services when indicated. Annual update for staff members ensures the workforce is knowledgeable about current contagious disease concerns.

1. Require TB screening for all patients of certified CD treatment programs.
2. Require provision of education about TB and other contagious diseases to patients of certified CD treatment programs. Currently required by Washington Administrative Code 388-805-300(12) (c).

*Expected Outcomes/Measures*

First-year target/outcome measurement (Progress to end of SFY 2014):

1. At least 80 percent of patients are screened for TB.
2. Continue to incorporate language in contracts regarding TB education.

Second-year target/outcome measurement (Final to end of SFY 2015):

1. Increase by at least 5 percent from the previous year the number of patients who are screened for TB.
2. 80 percent of patients receiving public-funded treatment are screened for TB.

***Substance Abuse Treatment –Adults Strategies***

Washington State provides a continuum of residential and outpatient chemical dependency treatment services which are both state and federally funded. The strategy of the adult residential service system is through improved efficiencies provide services to treat chemical dependency, and maintain long-term recovery. Based on the statewide penetration rate:

1. Increase the number of persons admitted into outpatient.
2. Increase the number of person considered to be retained as per Washington States’ retention measure description.
3. Increase the number of persons admitted into residential care.
4. Increase in the overall completion rate of patients entering into treatment.

*Expected Outcomes/Measures*

First-year target/outcome measurement (Progress to end of SFY 2014):

1. Increase outpatient admissions by 1 percent.
2. Increase retention by 1 percent.
3. Increase residential admissions by 1 percent.
4. Adult residential completion is broken into types of residential treatment in Washington State:
  - Intensive Inpatient - increase of 1percent.
  - Long-Term - Increase of 1 percent.
  - Recovery House - Maintain the current rate as set in SFY 2012.
  - ITA - Maintain the current rate as set in SFY 2012.

Second-year target/outcome measurement (Final to end of SFY 2015):

1. Increase outpatient admissions by 2 percent.
2. Increase retention by 2 percent.
3. Increase residential admissions by 2 percent.
4. Adult residential completion is broken into types of residential treatment in Washington State.
  - Intensive Inpatient baseline - Increase of 2%.
  - Long-Term - Increase of 2 percent.
  - Recovery House - Maintain the current rate as set in SFY 2012.
  - ITA baseline - Maintain the current rate as set in SFY 2012.

***Substance Abuse Treatment – Older Adults Strategies***

Aging Adult Chemical Dependency Treatment Services is a state and community based effort to coordinate substance abuse services in a community-based setting and a continuum of care by using ASAM placement to improve prevention, early identification, intervention, treatment, and aftercare. Services that are person-driven, occur via many pathways, are holistic and supported by peers, social networks, and community members, are culturally-based and provide hope for the individual and families using community strengths that create respect, recovery, and resiliency.

- Improve quality of treatment, cost containment, and impact on our most vulnerable populations. We have a tracking mechanism (TARGET and County Reports) to evaluate the progress in improving health equity, access, service use, and outcomes to develop targeted outreach, engagement, enrollment, and intervention strategies to reduce behavioral health disparities.

*Expected Outcomes/Measures*

First-year target/outcome measurement (Progress to end of SFY 2014):

- Based on a statewide penetration rate increase 1 percent for treatment admits for Older Adult Outpatient Treatment.

Second-year target/outcome measurement (Final to end of SFY 2015):

- Based on a statewide penetration rate increase 1 percent from previous year treatment admits provided for Older Adult Outpatient Treatment.

***Mental Health Promotion Strategy***

- ***Child-focused mental health promotion and support programs***

We will use Mental Health Block Grant Funds to implement three evidence-based projects targeted at children ages 4 - 12, or pre-school through 6th grade (Primary Project, Good Behavior Game and Positive Parenting Program (Triple P)). These strategies will be used to reduce the prevalence of childhood SED, including depression and anxiety. Each strategy will have an evaluation component to assess whether program goals and objectives are met. The strategies will emphasize development of effective and productive classroom management practices that engender positive mental health (Good Behavior Game - universal populations), service provision for children identified as having early childhood adjustment difficulties (Primary Project - selective populations), and support for parents around child rearing and child development (Positive Parenting Program (Triple P) - selective and indicated populations).

But we will insist on developing partnerships that will ensure local sustainability. For instance, with the parent support strategy, we have set up a system in the state for primary care providers to be paid from the state's basic health plan for providing the services. This will help ensure the continued delivery of the services even after Mental Health Block Grant funds are withdrawn.

- ***Suicide Prevention Task Force***

Working with other state agencies and organizations, as well as community behavioral health providers, monitor when and where suicides are occurring, patterns associated with suicides, the presence of contagions and organize responses to communities when suicides occur. The group will also work to develop systems for making information about suicides and suicide attempts timelier and more accurate. And the group will develop and disseminate materials to communities impacted by suicide, educate the media about responsible coverage of suicide-related stories, and to decrease stigmatization associated with help-seeking behavior. Initial membership on the group will be agencies and organizations impacted by suicide that provide services statewide. The initial membership includes: Division of Behavioral Health and Recovery (co-convener), Department of Early Learning (co-convener), Department of Health, Children's Administration, Office of Superintendent of Public Instruction, Division of Juvenile Rehabilitation, Youth Suicide Prevention Program, and Northwest Portland Area Indian Health Board. Membership will be expanded to include community-based suicide prevention groups, suicide survivors and families of suicide victims once the group develops some initial strategic directions.

- ***Community awareness of suicide risks and referral procedures***

Support the Training of Trainers workshops in western and eastern Washington for established and – where available – evidence-based community awareness-focused suicide prevention programs. The strategy will provide accurate information about which population groups are most involved in suicides, the



relationship between substance abuse and suicide, signs and symptoms of persons contemplating suicide, and referral sources and techniques. The trained trainers would then become resources that local communities could utilize to increase their own awareness of suicide risks and referral protocols.

*Expected Measurement/Outcome*

First-year target/outcome measurement (Progress to end of SFY 2014):

- In each case we will look for increases in desired behavior as a result of the intervention, e.g., increases in time spent on instructional tasks or increases in reports of increased functioning. With each of these evidence-based programs, proper implementation should yield changes in underlying behaviors such as depression and anxiety.
- Changes in data systems related to suicide and suicide attempts, number of participants in task force will be reviewed.
- Strategies for awareness developed based on comparison of pre- and post-tests in community trainings

Second-year target/outcome measurement (Final to end of SFY 2015):

- The same measurement strategies will be used in year two as in year one. But the students from the first year will have graduated to another grade level. We will not be measuring the progress of the graduating students but will continue to measure the performance of persons in the focus grade population.
- Implement changes in data systems related to suicide and suicide attempts, number of participants in task force.
- Implement strategies for awareness developed based on comparison of pre- and post-tests in community trainings conducted in the previous year.

***Mental Health Services for Youth Strategy***

1. Connect eligible children and youth to treatment and supports for those who are not Medicaid eligible or for services/supports Medicaid-funded.

Washington State, through its contracted Regional Support Networks (RSNs), strives to provide a range of brief and community level interventions to children and youth, and their families, who have been diagnosed with mental health conditions that interfere with their ability to function in their home, community, and school according to RSN Access to Care Standards. Inpatient psychiatric care is provided as needed. In addition, the RSNs and their contracted network providers are responsible to provide crisis and stabilization services to any Washington resident who needs those services, including children and youth, who may or may not be Medicaid-eligible. The mental health provider agencies provide coordinated care to children and youth who often are involved in multiple systems and refer and connect those youth and their families to natural supports, and other community services to help meet their needs. RSNs respond to unique local needs, populations, and partnerships with child-serving systems and supports. This range of locally-driven services and supports is designed to meet geographical and diverse population needs and aid the child, youth, and their families to develop resiliency and improve their health and wellness status, address disparities, and improve satisfaction with life. The development of unique programs and supports provided to non-Medicaid-eligible youth or are not Medicaid-funded include:

- Support access to crisis stabilization and other intensive services in order to avoid costs in hospitals, ERs, and juvenile detention centers.
- Promote meaningful engagement in pro-social activities with peer-to-peer organizations to address the goal of improving satisfaction with quality of life, including measures of recovery and resilience.
- Flexible funding and supports.
- Providing wraparound process
- Outreach and education regarding the mental health system, access, levels of care, and community supports provided to family members of children and youth with serious emotional disturbances.

DBHR’s primary strategy to further the goals of the federal block grant is to continue to afford the RSNs the flexibility to meet the needs of their populations while focusing on the goals identified in this application. The intended outcome is to ensure effective services provided across populations with measurable outcomes and performance indicators.

2. Increase access and readiness to provide evidence- and research-based practices for children and youth with serious emotional disturbances.

This strategy addresses quality of care practices and will assist with overall improved health and wellness status. Washington State supports the development of evidence-based practices and is committed to developing the workforce for further availability and sustainability of EBPs. Washington State is

committed to assisting the state's expansion of Trauma-Focused CBT and wraparound, among other EBPs to be identified. Wraparound is an intensive, individualized care planning and management process, and looks holistically at the needs of children, youth, and their families. Because of this holistic focus, improving educational outcomes such as graduation rates and school attendance is expected in wraparound results.

3. Maintain commitment to development of youth and family voice, leadership, and peer-to-peer support.

Washington State continues to develop and expand the availability of peer support, develop the governance structure of Family, Youth, and System Partner Roundtables (FYSPRTs) at the state and local levels, and promote youth and family leadership and support activities throughout the state. These efforts to expand the voice and reach of the wisdom from lived experiences of families and youth meet all of the above goals.

4. Develop the state's capacity to track progress on meaningful outcomes for youth, families, providers, system partners and taxpayers.

Washington will establish a system to support this statewide implementation for measuring the needs and strengths of youth who need intensive mental health services. DBHR will continue the partnership with the cross-system data quality team to evaluate outcomes for the children and youth who cross multiple systems. We intend to address children and youth's health and wellness status by decreasing population disparities and improving satisfaction with quality of life.

*Expected Measurement/Outcomes*

First-year target/outcome measurement (Progress to end of SFY 2014):

1. RSNs and other DBHR contractors will report types of services and supports provided to client, including their age.
2. Implementation of new EBP tracking system to demonstrate which children and youth received an EBP.
3. RSNs and other DBHR contractors will report the numbers and types of youth and family peer support, leadership, and policy development activities attended by youth and families.
4. Start-up of the Child Adolescent Needs and Strength tool occurred. Cross-system Data Quality team met regularly and reviewed outcome data.

Second-year target/outcome measurement (Final to end of SFY 2015):

1. RSNs will document a process for establishing measures of effectiveness for services and supports and continue to document age of client type and service type.
2. Maintenance of the EBP tracking system with an increase of 10 percent from the previous in the EBPs provided.
3. Develop regional-statewide database of providers offering specific EBPs. 10 percent increase from numbers documented in year one for family/youth support and participation activities.

4. CANS implementation continues and numbers of certified users is maintained. Cross-system Data Quality Team develops recommendations for improvements for the statewide FYSPRT and DBHR Quality Improvement Committee based on review of quality measures.

***Mental Health Services for Young Adults Strategy***

1. Evaluate community practices for Transition Age Youth and develop implementation guides to address the needs of Transition Age Youth.

While the transition from adolescence to adulthood is challenging for all young people, it can be especially difficult for youth with mental health needs who often face unemployment, underemployment, and discrimination when they enter the workforce. Adding to these challenges, youth with mental health needs often find it difficult to find or maintain services they need to successfully transition to adulthood including mental health treatment, employment and vocational rehabilitation, and housing. Providing appropriate services and supports to young people with mental health needs throughout the critical transition years increases their chances of becoming self-sufficient adults and reduces long-term dependency on public systems and other negative consequences such as social isolation and suicide.

The Department has facilitated efforts in the last few years to identify a more collaborative and systemic approach to serving this population across youth-serving systems. In October 2012, DBHR required Regional Support Networks (RSNs) to identify a process for addressing the needs of Transition Age Youth (TAY) (ages 16-21) including a comprehensive transition plan linked across systems that identify goals, objectives, strategies, supports, and outcomes; individual mental health needs in the context of a TAY, including meaningful employment, post-secondary education, technical training, housing, community supports, natural supports, and cross-system coordination with other system providers; transition services into the adult system as needed; and developmentally and culturally appropriate services.

DBHR will evaluate the progress and implementation strategies at each RSN to meet the TAY contract language in a cross-system partnership with RSN representatives, youth, families, and other stakeholders. Recommendations for statewide system improvements, workforce development needs, and best practices will be reflected in TAY implementation guides and targets for policy and practice improvements identified.

Additionally, the report will be informed by DBHR’s development of a data set and reporting mechanism for RSNs to report all block grant activities for children, transition aged youth, adults and older adults in order to ensure that the DBHR can reliably identify the population served, the attributes of that population, the services provided, and as applicable, the outcomes of those services.

*Expected Measurement/Outcomes*

First-year target/outcome measurement (Progress to end of SFY 2014):

- Evaluation of RSN responses and numbers youth in transition served by RSNs.

Second-year target/outcome measurement (Progress to end of SFY 2015):

- Implementation guides for TAY best practices and policy recommendations to improve system response to TAY.

***Mental Health Services for Adults Strategy***

1. Continue to contract for a range of effective services across populations while maintaining flexibility to Regional Support Networks to prioritize services locally.

Washington State’s Mental Health strategies in furthering the goals of the Federal Block Grant will continue to rely on service delivery through Regional Support Networks (RSNs). To this end, contracts with the RSNs will continue to support flexibility to meet the needs of their populations based on local planning efforts while at the same time focusing on the goals identified in this application. The intended outcome is to ensure effective services are provided across populations with measurable outcomes and performance indicators.

RSN services provided in the past year have been consistent with the Behavioral Health Outcomes and are expected to continue as such. Services in the past year have included:

- Mental Health First Aid
- Housing/Rental Assistance and Support Services
- LGBTQ Specific Counseling and Support
- Supported Education
- Crisis Intervention & Stabilization Services
- Clubhouse
- Integrated Co-occurring Disorder Treatment
- Forensic PACT
- Gatekeeper Services
- Mental Health Promotion Activities using NAMI models
- Grocery Vouchers
- Mental Health Medication and Treatment Clinics for Low-Income Non-Medicaid Consumers

DBHR will ensure that all RSN contracts emphasize the delivery of effective strategies intended to address the goals of this application as articulated in the DBHR Behavioral Health Outcomes.

2. Increase the employment rate for consumers receiving outpatient mental health services.

- Implement the Ticket to Work program through the establishment of an Employment Network within the Division of Behavioral Health and Recovery.
- Increase the number of licensed mental health agencies that are contracted by the Division of Vocational Rehabilitation to provide employment services.

3. Increase stable housing for consumers:

- Promote the use of evidence-based practices, research-based practices, and promising practices including Permanent Supportive Housing.

- Use outreach teams to engage individuals who are homeless or at risk of homelessness.
  - Assist individuals with housing resources to obtain or maintain stable housing after discharge from an institutional setting.
4. Maintain opportunities for consumers to receive supported education and opportunities for meaningful activity to improve health and wellness and reduce involvement with criminal justice.
- DBHR will promote the use of evidence-based practices, Research-based practices, and promising practices including Supported Employment, Supported Education, Peer Services, Clubhouse Services, consumer and family operated services.
3. Improve consistency of reporting for block grant activities and outcomes.
- Improve the current data set and reporting mechanisms for RSNs to report all block grant activities to ensure that DBHR can reliably identify the population served, the attributes of that population, the services provided, and the outcomes of those services.
4. Address fidelity monitoring and implementation of EBPs to include Program for Assertive Community Treatment, Illness Management and Recovery and Integrated Dual Disorder Treatment.
- The PACT team implementation model is a variation of the PACT/ACT EBP, modified to work with forensic population.
- DBHR will contract with an external evaluator to monitor fidelity implementation of forensic PACT teams.
5. Continue to participate in regularly scheduled government-to-government meetings with tribal representatives as an avenue to discuss tribal-centric mental health.
- DBHR staff will be in attendance at all Tribal-centric mental health meetings.

*Expected Measurement/Outcomes*

First-year target/outcome measurement (Progress to end of SFY 2014):

1. Effective mental health service delivery.
  - All RSN plans will be reviewed for applicability to furthering the DBHR Behavioral Health Outcomes.
2. Employment
  - Increase the number of Ticket to Work “tickets” for mental health consumers.
  - Increase the percentage of clients whose employment status changes within the public outpatient services to 12.5 percent% (currently at 8 percent of consumers).
  - Increase the number of agencies that are licensed/certified to provide



limited scope employment or peer services by 10 percent (currently 27 percent of agencies).

3. Housing
  - 25 percent of our community mental health agencies will report that they are providing evidence-based practice Permanent Supportive Housing.
  - Establish a baseline for determining the number of people discharged from state hospitals with an unmet housing need.
  - Identify gaps and strategies to assist individuals from becoming homeless 12 months from discharge.
4. Meaningful Activities
  - Develop a reporting method for RSNs to report subcontracted peer-operated or peer-mentored services to establish a baseline on the number of consumers served.
5. Reporting
  - Develop a timeline for implementation of enhanced reporting of block grant activities.
6. PACT Team Fidelity
  - All 11 (100 percent) PACT Teams will implement services with fidelity.
7. Tribal-centric mental health
  - DBHR staff participation at 100 percent of Tribal-centric mental health meetings.

Second-year target/outcome measurement (Progress to end of SFY 2015):

1. Effective mental health service delivery.
  - All RSN plans will be reviewed for applicability to further the DBHR Behavioral Health Outcomes.
2. Employment
  - Increase the number of Ticket to Work “tickets” assigned for mental health consumers to DBHR’s Employment Network.
  - Increase the percentage of clients whose employment status changes within the public outpatient services to 12.5 percent.
  - Increase the number of agencies that are licensed/certified to provide limited scope employment or peer services by 10 percent.
3. Housing
  - 25 percent of our community mental health agencies will report that they are providing evidence-based practice Permanent Supportive Housing.
  - Implement a plan to address identified gaps and strategies to assist individuals from becoming homeless 12 months from discharge from a state hospital.

- Reduce the number of consumers who report being homeless 12 months from discharge from a state hospital.
- 4. Meaningful Activities
  - Maintain or increase the number of consumers served through peer-operated or peer-mentored services compared to the year 1 baseline.
- 5. Reporting
  - Come to an agreement with RSNs on the data set, reporting mechanism(s), and timeline of enhanced reporting of block grant activities.
- 6. PACT Team Fidelity
  - All 11 (100 percent) PACT Teams will be found to be implementing services with fidelity.
- 7. Tribal-centric mental health
  - DBHR staff participation at 100 percent of tribal-centric mental health meetings.

***Mental Health Services for Older Adults Strategy***

1. Address stigma regarding mental health services by older adults.
  - DBHR will develop a strategic plan in collaboration with a broad range of partners to address stigma regarding mental health services by older adults.
  - DBHR will develop a formal mechanism to communicate with older consumers.
  
2. Address a lack of access to mental health services by older adults.
  - Promote the use of outreach mental health services provided in the individual's home, including private homes, adult family homes, and nursing facilities and the use of co-located behavioral health in primary care.
  - Encourage the use of validated screening tools in Health Homes to identify anxiety and depression.

*Expected Measurement/Outcomes*

First-year target/outcome measurement (Progress to end of SFY 2014):

1. Stigma
  - Present a draft plan to address stigma by older adults to the Behavioral Health Advisory Committee for review and comment.
  - Receive approval from the Behavioral Health Advisory Committee on the mechanism for communication with older adult consumers.
  
2. Lack of Access
  - Develop a routine report and query in the Consumer Information System (CIS) mental health MIS to monitor services by location and consumer age to establish a baseline of penetration rate.

Second-year target/outcome measurement (Progress to end of SFY 2015):

1. Stigma
  - Present a final plan to address stigma by older adults to the Behavioral Health Advisory Committee for review and approval.
  - Implement the approved mechanism for communication with older adult consumers.
  
2. Lack of Access
  - Identify service gaps and increase services to older adults in those areas.