Washington

UNIFORM APPLICATION
FY 2016/2017 - STATE BEHAVORIAL HEALTH ASSESSMENT AND PLAN

SUBSTANCE ABUSE PREVENTION AND TREATMENT
and
COMMUNITY MENTAL HEALTH SERVICES
BLOCK GRANT

OMB - Approved 06/12/2015 - Expires 06/30/2018
(generated on 08/31/2015 12.39.45 PM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

and

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

State Information

State Information

Plan Year

Start Year 2016

End Year 2017

State SAPT DUNS Number

Number 127347115

Expiration Date

I. State Agency to be the SAPT Grantee for the Block Grant

Agency Name Department of Social and Health Services

Organizational Unit Behavioral Health Services Integration Administration/Division of Behavioral Health and Recovery

Mailing Address PO Box 45330

City Olympia

Zip Code 98504-5330

II. Contact Person for the SAPT Grantee of the Block Grant

First Name Chris

Last Name Imhoff

Agency Name Department of Social and Health Services

Mailing Address PO Box 45330

City Olympia

Zip Code 98504-5330

Telephone 360-725-3700

Fax 360-725-2280

Email Address imhofC@dshs.wa.gov

State CMHS DUNS Number

Number 12734115

Expiration Date

I. State Agency to be the CMHS Grantee for the Block Grant

Agency Name Department of Social and Health Services

Organizational Unit Behavioral Health Services Integration Administration/Division of Behavioral Health and Recovery

Mailing Address PO Box 45330

City Olympia

Zip Code 98504-5330

II. Contact Person for the CMHS Grantee of the Block Grant

First Name Chris

Last Name Imhoff

Agency Name Department of Social and Health Services

Mailing Address PO Box 45330

City	Olympia
Zip Code	98504-5330
Telephone	360-725-3770
Fax	360-725-2280
Email Address	imhofc@dshs.wa.gov

III. State Expenditure Period (Most recent State expenditure period that is closed out)

From	7/1/2014
To	6/30/2015

IV. Date Submitted

Submission Date	8/31/2015 12:37:53 PM
Revision Date	

V. Contact Person Responsible for Application Submission

First Name	Sandra
Last Name	Mena-Tyree
Telephone	360-725-3750
Fax	
Email Address	menasa@dshs.wa.gov

Footnotes:

State Information

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

Fiscal Year 2016

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

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
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ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

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

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance. 16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

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

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

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

3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

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

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

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

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

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

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

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

Signature of CEO or Designee[1]: _____

Title: Director

Date Signed: _____

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

I. State Information

Chief Executive Officer's Funding Agreements, Assurances Non-Construction Programs and Certifications (Form 3)
Fiscal Year 2016-2017

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Substance Abuse Prevention and Treatment Block Grant Program
as authorized by
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and
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State: Washington

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

Signature of CEO or Designee[1]: Chris Imhoff

Title: Director DDA/R

Date Signed: 06/26/2015
mm/dd/yyyy

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2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
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The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

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

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State: Washington

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

Signature of CEO or Designee[1]: Chris Imhoff

Title: Director DDA/R

Date Signed: 06/26/2015
mm/dd/yyyy

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7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to

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

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

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

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

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

State Information

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

Fiscal Year 2016

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

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ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPMâ€™s Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
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I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

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

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

Signature of CEO or Designee[1]: _____

Title: Director

Date Signed: _____

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

I. State Information

Chief Executive Officer's Funding Agreements, Assurances Non-Construction Programs and Certifications (Form 03)
Fiscal Year 2016/17

U.S. Department of Health and Human Services
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Funding Agreements
as required by
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Signature of CEO or Designee[1]: Chris Imhoff

Title: Director DOHR

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mm/dd/yyyy

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Footnotes:

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Fiscal Year 2016/17

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Signature of CEO or Designee[1]: Chris Imhoff

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15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance. 16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

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

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

State Information

Disclosure of Lobbying Activities

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

Standard Form LLL (click here)

Name	
Title	
Organization	

Signature: _____ Date: _____

Footnotes:

No Lobbying Activities to report

Planning Steps

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

Narrative Question:

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

Footnotes:

The Department of Social and Health Services (DSHS) is Washington's largest state agency and houses the majority of the Washington state's social and behavioral health programs. In any given month, DSHS provides some type of shelter, care, protection, and/or support to 2.2 million of our state's 6.8 million people.

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

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

DSHS collaborates with the State Medicaid Authority (the Health Care Authority-HCA) through formal Memoranda of Understanding (MOU) for behavioral health services. Prevention and promotion activities are coordinated with the Office of Superintendent of Public Instruction (OSPI) for Community Prevention Wellness Initiatives, the Liquor Cannabis Board (LCB) for Alcohol and Marijuana Initiative, and the Department of Health (DOH) for Suicide, Tobacco and Marijuana Prevention.

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

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

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

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

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

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

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

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

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

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

Washington State and the DBHR strive to be in the forefront of system changes, as following projects illustrate:
- Building on a continuum of services including, prevention, intervention, treatment and recovery support, which incorporate evidence-based programs and practices whenever possible.
- Redesigning the children's mental health system to expand wraparound services throughout the state.
- Developing an innovative program to address transition age youth who have experienced a first episode psychosis.
- Integrating the purchasing of substance use disorder and mental health treatment services into a single managed care contract by April 1, 2016.

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

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

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

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

As we assess the Washington state behavioral health service system, it is clear the

complexity of the system defies a simple description. In the next few sections, the system will be described from several lenses:

- The contracting of the state's public behavioral health system with a particular focus on how the system is currently organized around children/youth and adult services and how it will look in April 2016 as we transition to integrated purchasing of services through managed care contracts..
- Data informed decision based on a statewide needs assessment
- An overview of the continuum of care offered by Washington State.
- The strengths and needs of behavioral health system and
- Descriptions of block grant required programs.

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.

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

DBHR supports these six statewide conferences and trainings each year:
1. Behavioral Health Conference
2. Co-Occurring Disorders and Treatment Conference
3. Saying It Out Loud Conference
4. Prevention Summit
5. Spring Youth Forum
6. Summer Coalition Leadership Institute

The Behavioral Health Conference is a two-day statewide behavioral healthcare conference presented by the Washington Community Mental Health Council (WCMHC) and supported by the Federal Block grant funding administered through DBHR. This year's conference, "Fulfilling the Promise of Integrated Care," was held June 17-19, 2015, in Vancouver.
The conference audience includes mental health professionals in areas of aging, developmental disabilities, children's services, substance use disorder and other specialties, consumers and consumer advocates, administrators, staff of public and nonprofit agencies and other stakeholders. This year's funding was increased to support the coordination of registration scholarships for up to 200 consumers/consumer advocates, 70 DBHR staff, and 16 Behavioral Health Advisory Committee (BHAC) members to attend the event.

The 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 Saying it Out Loud Conference is planned in partnership with the Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) community and several divisions or offices within the department (e.g., DBHR, Children's Administration, Division of Vocational Rehabilitation, Development Disabilities Administration, Rehabilitation Administration, and Office of Diversity and Inclusion) to bring together professionals from the diverse fields of social work, mental health, substance use disorder treatment, and substance abuse prevention. It focuses on the impacts of substance use disorder and mental health in the LGBTQ community, as well as current resources and research. DSHS has a long-standing record of supporting and partnering with the LGBTQ community.

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

The Prevention Summit provides education and training to prevent alcohol, tobacco, and other drug use, with an emphasis on preventing underage drinking and prescription drug abuse. Goals include increasing knowledge of prevention science and practice, increasing awareness of state issues, and promoting the need for continued prevention work by professionals and youth. In 2014, a total of 658 people attended the conference with 298 youth making up 48 teams attended leadership workshops for developing and implementing prevention projects in their schools and communities. The majority (92%) of conference participants would recommend the conference to others.

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

The Summer Coalition Leadership Institute is an annual three-day training event to advance the prevention workforce with knowledge and skills. The audience is primarily community coalition coordinators, coalition leadership, Educational Service District partners, and state agency Prevention Policy Consortium Members. Topics this year included understanding academic impacts related to adolescent and young adult substance use. These sessions offered knowledge building to interpret the trend data, ways to develop partnerships, and effective prevention strategies. The participants also received one full-day of training on reducing Health Disparities in Washington State. Other sessions included training on basic facilitation skills and group conflict resolution. This training event is an opportunity to highlight other programs having success in the CPWI communities and for the coordinators to network and share successes and challenges to learn from each other. This training is offered at no cost and is written into our Partnerships for Success application and it is also supported with the SABG funding. This year 14 of the 17 hours were acknowledged by the Prevention Specialist Certification Board of Washington for Continuing Education Hours that prevention professionals can use to support their credential.

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 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

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

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.

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. Other trainings include Mental Health First Aid, Peer Specialist Certification, and Wellness Recovery Action Plan.

CONTRACTING OF THE PUBLIC BEHAVIORAL HEALTH SYSTEM

Mental Health Contracting

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

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

The RSNs are required to prioritize state funds for crisis services and involuntary treatment act services. Consumers obtain services, both Medicaid and non-Medicaid, through one of 11 RSNs and their network of over 150 community-based mental health providers.

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

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

State Hospitals

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

Substance Use Disorder Contracting

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

Direct Contracting
DBHR contracts directly with state-certified substance use disorder residential treatment programs for youth, adult, and pregnant and parenting women. Contracts include specific assessment and counseling requirements, staffing ratios, reporting and referral requirements, and any appropriate block grant requirements. Treatment for family and significant others is included, as well as relapse and long-term recovery education and counseling.

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

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

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

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

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

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

Tribal Contracting
State Tribal Agreements and/or Contracts
DBHR has continued to provide funding opportunities for tribes. Approximately $16 million has been made available during this biennium to sup¬port chemical dependency prevention and treatment programs and $255,000 has been provided to enhance mental health promotion services adminis¬tered by our Tribes.

Medicaid - Federal Memorandum of Agreement (IHS Encounter Rate)
In July 1997, a Memorandum of Agreement (MOA) process was initiated by the federal Center of Medicare/Medicaid Services and Indian Health Services through the Division of Behavioral Health and Recovery for Title XIX Medicaid-eligible American Indian

clients. Under the terms of the federal MOA, tribally owned clinics authorized through the Indian Health Services are reimbursed at 100% of the encounter rate for outpatient chemical dependency and mental health services to eligible American Indian clients and half the encounter rate for outpatient services to non-native clients. In conjunction with the Health Care Authority (HCA) DBHR offers technical assistance, training and consultation to Tribal FQHCs and 638 Mental Health Programs on billing procedures and Medicaid regulations.

Mental Health Contracts
DBHR contracts with tribes, via DSHS Consolidated Contracts for mental health promotion services funded through State dollars. However, DBHR does not directly contract with tribes for managed care mental health services–statute requires that all waivered mental health funds are contracted through the RSN system. Tribes and RSNs may enter into contracts for provision of services. These services would include provision of mental health services through licensed tribal community mental health centers, provision of Native Amer¬ican specialist consultations for RSN provider agencies, and block grant contracts. Mental health services provided by Tribal Mental Health providers are billed at the IHS Encounter Rate through HCA.

Substance Use Disorder Services Contracts
Tribal Chemical Dependency Services are provided through DSHS Consolidated Contracts. These contracts provide financial support for the 29 federally recognized tribes for culturally-based treatment services and prevention activities. Tribal programs provide services mostly to the tribal populations, but at the discretion of the tribe can serve nontribal members as well.

Tribal substance abuse prevention and mental health promotion programs are specific to each tribe’s local needs, culture and traditions. Tribes select evidence-based programs or develop tribal prevention programs in order to best serve their members and sur-rounding community members. Tribes develop an annual prevention program plan with the assistance of DSHS’s Office of Indian Policy and DBHR.

Examples of Tribal substance abuse prevention, mental health promotion and suicide prevention programs:
- After School Tutoring Programs
- Life Skills Training
- Tribal Youth Honoring
- Canoe Journeys
- Drum Making
- Inner Generational Cultural Preservation
- American Indian Life Skills Development
- Model Adolescent Suicide Prevention Program (MASPP)
- CAST (Coping And Support Training)
- QPR (Question, Persuade, and Refer) Gatekeeper Training for Suicide Prevention
- Sources of Strength
- Community Activities; including Community Dinner, Prevention Programming, and Cultural Strengthening and Revitalization

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

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

Mental Health
RSNs, through contracts with community mental health agencies, provide a complete array of services to adults with serious mental illness (SMI) who meet the Access to Care standards (diagnosis and level of functional impairment) and standardized medical necessity criteria. The list of possible services may include brief intervention, crisis services, family treatment, freestanding evaluation and treatment, individual and group treatment, high intensity treatment, medication management and monitoring, residential treatment, and stabilization services.

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

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

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

Approximately 70% of individuals at the state hospitals are under civil commitment orders. The remaining 30% receive court-ordered forensic services. These include:
- Evaluation of individuals for competency to stand trial.
- Treatment to restore competency for those deemed not competent to stand trial.
- Ongoing treatment for individuals found to be not guilty by reason of insanity.

The Regional Support Networks provide community mental health services to adults with serious, persistent, and chronic mental health needs and to children and youth under the age of 19 who are experiencing serious emotional disorders. Each RSN contracts with provider groups and commu¬nity mental health agencies. Each RSN network serves all Medicaid eligibles within its geographical area–including American Indians and Alaskan Natives. RSN crisis services are available to all residents, without regard to funding or Medicaid eligibility.

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

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

There are a number of ways a person can receive treatment services. Most people will find that treatment services are part of their health insurance package purchased when they go through the HealthPlanFinder – even and especially those that

are “newly eligible”. A client may be referred, who doesn’t appear to have health coverage, and to the HealthPlanFinder but especially if they need services.

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

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

There are currently three types of residential substance use disorder (SUD) treatment for adults in the state. Intensive inpatient treatment provides a concentrated program, of individual and group counseling, education, and activities for people who are addicted to substances and their families. There are currently 20 adult intensive inpatient providers with a capacity of 552 slots statewide. Each patient participating in this level of substance use disorder treatment receives a minimum of 20 hours of treatment services each week. Long-term treatment provides treatment for the chronically impaired adult with impaired self-maintenance capabilities. There are currently seven adult long-term residential providers with a total capacity of 135 slots. Each patient participating in this level of substance use disorder treatment receives a minimum of four hours of treatment per week. Recovery Houses provide personal care and treatment, with social, vocational, and recreational activities to aid with patient adjustment to abstinence, as well as with job training, employment, or other community activities. There are currently five adult recovery house providers with a capacity of 58 beds statewide. Each patient participating in this level of substance use disorder treatment receives a minimum of five hours of treatment services per week.

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

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

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

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

Washington has codified statutes aimed at protecting individuals and the community by providing for involuntary substance use disorder treatment. Involuntary commitment is the mandatory placement in a treatment facility of an individual who

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

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

CHILDREN AND YOUTH BEHAVIORAL HEALTH SYSTEM

Mental Health
RSNs, through contracts with community mental health agencies, provide a complete array of services to children and youth with serious emotional disorders (SEDs) who meet the Access to Care standard (diagnosis and level of functional impairment) and standardized medical necessity criteria. The list of possible services may include brief intervention, crisis services, family treatment, freestanding evaluation and treatment, individual and group treatment, high intensity treatment, medication management and monitoring, residential treatment, and stabilization services.

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

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

WISe is different from traditional mental health services in a number of ways:
- The intensity of services available within the community: WISe is set up to keep youth with intense mental health needs safe in their own communities and receiving a level of services that meets their individual needs. This higher level of services within communities is not currently available in every county across state, and at times youth had to go into inpatient treatment settings to get the level of care they needed, instead of being able to get the help they needed while staying in their homes.
- The time and location of services: WISe services are not office-based. They take place in locations that work best for the youth and family, at times that work best for the family (including at their house on evenings and weekends).
- Team-based approach: WISe relies on the strengths of an entire team, working together to meet the needs identified by the youth and family. WISe uses a wraparound model in which teams are made up of both natural supports and individuals

from the child-serving system partners that the youth and family may have in their lives at the time. Some examples of these partners might be school personnel, a probation officer, a religious leader, a chemical dependency counselor, or a coach/teacher of an extracurricular activity. Youth partners and/or family partners are also a part of every team to ensure youth and family voice and choice is heard. The team, driven by youth and family choice, creates ONE cross-system Care Plan that includes strategies and supports to overcome the challenges met by the youth and his or her family, while building upon the family's resiliency. This intensive care coordination between all partners is critical in meeting the needs of the youth's well-being in its entirety.

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

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

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

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

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

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

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

Through community presentations, clinical trainings, fact sheets, and publications, we will increase awareness of schizophrenia and psychosis, reduce the stigma associated with schizophrenia and psychosis, encourage people to get the facts about

symptoms, and increase early identification and referrals for young people experiencing a first episode of psychosis.

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

State certified outpatient programs generally provide substance use disorder assessments and alcohol-/drug-free counseling for adolescents ages 10 through 17 (but young adults ages 18-20 or children under 10 may be served in youth agencies if developmentally appropriate, with approval of a DBHR manager). Collateral and family support services may also be provided to family members of youth. Outpatient treatment programs are designed to diagnose, stabilize, counsel, and build family and social support systems to promote personal development and recovery.

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

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

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

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

AN OVERVIEW OF THE CONTINUUM OF CARE

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

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

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

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

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

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

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

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

Early Intervention
DBHR has supported early intervention collaborative projects with other

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

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

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

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

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

DBHR is a recipient of the State Adolescent Treatment Enhancement and Dissemination grant that will allow the opportunity to enhance treatment and recovery services for youth (ages 12 to 18) who have a substance use disorder diagnosis and youth who have a co-occurring substance use disorder and mental health disorder diagnosis (COD).

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

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

Mental Health Crisis Services are intended to stabilize the person in crisis, prevent further deterioration and provide immediate treatment and intervention in a location best suited to meet the needs of the individual and in the least

restrictive environment available. This may include services provided through crisis lines.

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

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

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

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

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

Another initiative supporting recovery in the past ten years has been Washington state's Project for Assistance in Transition for Homelessness (PATH) Program. PATH is a systematic collaboration between our mental health system and providers of community and government subsidized housing resources. This effort has provided thousands of units of housing for individuals with mental illness or co-occurring disorders who are homeless or at immediate risk of homelessness.

Residences that are alcohol- and drug-free are provided for women and their children through the Pregnant and Parenting Women (PPW) Housing Support Services. Recovery

support and linkages to community-based services are provided through this program. A care plan identifies community supports to maximize recovery. Case management coordinates outpatient substance abuse treatment and facilitates prenatal and post-natal medical care, financial assistance, social services, vocational services, childcare needs, and permanent housing.

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

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

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

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

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

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

DBHR continues to develop infrastructure to support system of care approaches, particularly wraparound and Wellness Recovery Action Plan (WRAP). Ongoing activities include family-to-family networking and the Community Connectors Training

that brings families of children with complex needs together to develop sustainable community resources and connections. The CLIP (Children's Long-term Inpatient Program) Parent Training is held twice per year providing training and support for families with children who are hospitalized in psychiatric residential treatment facilities.

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

- Providing leadership as a member of the Executive Management Team.
- Advocating for both substance abuse and mental health consumers.
- Ensuring, by policy and contractual requirements, that advisory committees and planning groups include meaningful consumer voice.
- Assisting in the development and support of emerging consumer leadership.
- Supporting consumer networking at DBHR-supported conferences and trainings.
- Assisting with recovery-oriented training, including Certified Peer Counseling training.
- Promoting anti-stigma education.

OVERALL STRENGTHS OF THE BEHAVIORAL HEALTH SERVICES IN WASHINGTON

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

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

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

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

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

Tribal Programs

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

an opportunity to share information and discuss current issues. RSNs are also required to comply with the 7.01 Policy and must submit annual comprehensive plans detailing tribal/RSN relations to DBHR.

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

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

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

NEEDS OF WASHINGTON STATE'S BEHAVIORAL HEALTH SYSTEM

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

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

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

Providers
There are several challenges facing the provider systems in Washington State. The first of these is purely an issue of capacity. We are unable to develop the necessary prevention/intervention/health promotion that our research suggests would

be optimal. With the greatly increased size of the Medicaid-eligible population, there is considerable need to expand system capacity, to focus on workforce development, and to better integrate our systems.

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

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

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

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

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

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

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

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

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

There continues to be a need to address stigma and discrimination against those with behavioral health issues. Mental illness and substance use disorders become evident in a variety of settings where appropriate assistance and support is not readily available. We need to work at early identification and providing resources for support and assistance.
There is insufficient or inaccurate information collected on gender identity and on tribal affiliation/membership and this contributes to a feeling of not being respected or included. There is often a reluctance to amend or expand data collection to reflect these needs. Some specific population groups cannot be defined geographically, and for these groups there are no consistent data available (e.g., the population of GLBTQ persons, or children of military families, Native Americans not living on tribal lands) that would contribute to planning of prevention and culturally specific service efforts.

Planning Steps

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

Narrative Question:

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

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

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

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

Through the Healthy People Initiative[18] HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

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[18] http://www.healthypeople.gov/2020/default.aspx

Footnotes:

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

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

DBHR continues to integrate data-informed needs assessment with planning, policy development, service provision, and reporting. The State Epidemiological Outcomes Workgroup (SEOW) plays a important role in primary prevention and treatment planning. Chaired by the DBHR Office Chief for Decision Support and Evaluation and the State Epidemiologist for Non-Infectious Conditions from the Department Health (DOH), the SEOW is comprised of epidemiologists from multiple state agencies and universities tasked with monitoring and improving the behavioral health of the population. During the past year, the SEOW has provided guidance, as well as data support in identifying the state's prevention priorities through the State Prevention Policy Consortium.

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

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

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

In the wake of the new state marijuana laws, DBHR worked with researchers at the University of Washington to implement a survey using a convenience sample of young

adults to assess changing norms and behaviors. With a greater sample size than that available from the NSDUH and BRFSS, DBHR will be able to detect differences between subpopulations, age groups, and geographic areas. The web-based survey, which included questions about other substance use issues, will inform both prevention and treatment planning.

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

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

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

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

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

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

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

Mental health resource allocation will continue to be based on prevalence and treatment needs. For example, DBHR recently updated the state hospital bed

allocation formula with current prevalence rates of serious mental illnesses and prior utilization rates.

An important aspect of DBHR's surveillance work is the increasingly sophisticated access to data available for providers to help in their own assessment and planning. DBHR has created "the System for Communicating Outcomes, Performance & Evaluation (SCOPE) http://www.scopewa.net," a web-based Mental Health and Substance Abuse Performance Indicators. This framework consists of two broad functions: 1) standard reports, which typically address issues of general interest to constituents in pre-formatted output and 2) an ad hoc query function that allows users to perform analyses and data summaries using a drop-down menu interface. SCOPE is available to treatment providers, regional administrative entities, state program managers, and the general public. DBHR's SCOPE reporting system has fulfilled and supported the needs and strategy of former "Uniform Reporting System (URS)" and current "Client-Level Data." It has continued to support the monitoring of service access, quality, and utilization as well as consumer outcomes and to identify gaps and areas for improvement.

Current Priorities

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

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

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

There are three pieces of state legislation that are driving the data, reporting, and performance management priorities for DBHR: (1) Senate Bill 6312, which directs DSHS to change how it purchases mental health and substance use disorder services; and (2) House Bill 1519 and Senate Bill 5732, which direct DSHS and the Health Care Authority (HCA) to carry out multiple activities focused on improving the outcomes of adults who receive behavioral health services, including the establishment of accountability measures. To implement this legislation, DBHR is currently working to redesign its data system and align its reporting, performance measures, and quality improvement activities to support the system change to an integrated behavioral health managed care model as required by SB6312. DSHS is currently working towards transitioning to Behavioral Health Organizations (BHOs) which will purchase and administer public mental health and substance use disorder services starting in April 2016.

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

- Improvement in client health status
- Increases in client in participation in employment, education, and meaningful activities
- Reduced client involvement in criminal justice systems and increased access

to treatment for forensic patients
- Reduced avoidable use of hospital, emergency rooms, and crisis services
- Increased housing stability in the community
- Improved client satisfaction with quality of life
- Decreased population level disparities in access to treatment and treatment outcomes

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

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

Within Results Washington, DBHR has lead responsibility for six success metrics under the Healthy Youth and Adults success indicator in Goal Area 4 (Healthy and Safe Communities). Strategies to address each will be detailed later in the Priority, Goals, and Strategies of this application. DBHR's Results Washington success metrics include:
- Increase the number of adults (18 and older) receiving outpatient mental health services from 56,000 to 62,000 by June 30, 2015.
- Decrease the percentage of 10th graders who report smoking marijuana in the past 30 days from 19.3% in 2012 to 18% by 2017.
- Decrease the percentage of 10th graders who report drinking alcohol in the past 30 days from 27.7% to 24.8% (revised to 19%) by 2017.
- Increase the percent of mental health consumers receiving a service within seven days after discharge from inpatient settings from 59% to 65% by June 30, 2015.
- Increase outpatient chemical dependency treatment retention for adults from the FY 2013 average of 68% to 70.7% by June 30, 2015 (revised to 68.4% by June 30, 2017).
- Increase outpatient chemical dependency treatment retention for youth from the FY 2013 average of 74% to 76.2% by June 30, 2015 (revised to 73.8% by June 30, 2017).

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

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

Planning Steps

Quality and Data Collection Readiness

Narrative Question:

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

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

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

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

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

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

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

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

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

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

3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-identifying information)?

4. If not, what changes will the state need to make to be able to collect and report on these measures?

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Not Required

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Reducing Underage and Young Adults Substance Use

Priority Type: SAP

Population(s): (Adolescents w/SA and/or MH, LGBTQ, Children/Youth at Risk for BH Disorder, Underserved Racial and Ethnic Minorities)

Goal of the priority area:

Decrease the percentage of 10th graders who report using alcohol, marijuana, tobacco, and other drugs in the last 30 days.

Objective:

Strategies to attain the objective:

Decrease the percentage of 10th graders who report using alcohol, marijuana, tobacco, and other drugs in the last 30 days.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Maintain the number of Washington youth receiving direct prevention services from baseline: SFY15 34,219

Baseline Measurement: Washington State Healthy Youth Survey, 2014

First-year target/outcome measurement: Maintain number of prevention programs and participants from SFY15 baseline numbers: • 77 Community-wide programs implemented.• 28 Programs focused on addressing favorable attitudes• 34,219 Individuals reached. • 1,569 Hours of technical assistance provided to CPWI sites. • 48 Youth teams made up of 298 individuals attending the Prevention Summit.

Second-year target/outcome measurement: oShow decrease in substance use in 10th graders according to the Washington State Healthy Youth Survey, 2016. Maintain the number of prevention programs and participants from SFY15 baseline numbers: Community-wide programs implemented. Programs focused on addressing favorable attitudes. Individuals reached. Hours of technical assistance provided to CPWI sites. Youth teams and individuals attending the Prevention Summit. Determine feasibility of piloting and implementing SBIRT-like services in school-based settings.

Data Source:

Washington State Healthy Youth Survey, 2014

Description of Data:

10th Grade Substance Use Among Washington Youth

Data issues/caveats that affect outcome measures::

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

Priority #: 2

Priority Area: Increase Youth Outpatient Substance Use Disorder Treatment

Priority Type: SAT

Population(s): (Adolescents w/SA and/or MH, Students in College, LGBTQ, Rural, Criminal/Juvenile Justice, Persons with Disablities, Children/Youth at Risk for BH Disorder, Underserved Racial and Ethnic Minorities)

Goal of the priority area:

Increase percentage of youth outpatient substance use disorder treatment retention in youth from a state fiscal year average of 74.2% to 76.2%

Objective:

Strategies to attain the objective:

Explore new mechanism and protocols for case management and Continue using Performance Based Contracting to improve retention in Youth Outpatient, increase contracted target, and add technical assistance tools for use by providers

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Adult CD Outpatient Caseload & Adult Outpatient Treatment Retention by Governing County

Baseline Measurement:

First-year target/outcome measurement: Workgroup to review identified countermeasures for feasibility and potential impact

Second-year target/outcome measurement: Convene internal workgroup to establish timeline, implementation plan, and actual products for implementation

Data Source:

SCOPE/TARGET/Treatment Analyzer

Description of Data:

"SFY2013 Served" is an unduplicated count of youth (persons 17 years of age and younger) served in publically-funded outpatient treatment between July 1, 2012 and June 30, 2013.

Data issues/caveats that affect outcome measures::

• Lack of case management ability by the treatment programs for issues such as client engagement, money for transportation, and assistance to get into supportive housing. Youth outpatient clients not currently being retained at the rate that is set. There is not additional funding to implement trainings recommended by the A-3 workgroup.

Priority #: 3

Priority Area: Increase outpatient mental health services for adults

Priority Type: MHS

Population(s): SMI (Rural, Underserved Racial and Ethnic Minorities)

Goal of the priority area:

Increase number of adults (18 and over) receiving outpatient mental health services from 56,000 to 62,000

Objective:

Strategies to attain the objective:

•Convene Medicaid enrollment workgroup to determine best practices for enrollment at point of first contact. Gather data and resources regarding how potential consumers are identified and located through Geo-mapping and other available data systems. Convene Service Engagement Workgroup to address engagement in treatment at intake

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase the number of adults (18 and over) receiving outpatient mental health services

Baseline Measurement: Regional Support Network service data third quarter FY 2103

First-year target/outcome measurement: • Assemble population analysis to inform Medicaid Enrollment Workgroup. Convene Medicaid Enrollment Workgroup to determine best practices. Gather data to show impact of in-person supports/potential data for funding requests for ongoing in-person supports (in-person assisters). Convene Service Engagement Workgroup to address engagement in treatment at intake.

Second-year target/outcome measurement: •Improve access in underserved areas. Improve engagement at intake

Data Source:

Regional Support Network service data

Description of Data:

The number of adults (18 and over) receiving outpatient mental health services

Data issues/caveats that affect outcome measures::

•Lack of in-person supports to help consumers. Lack of consumer enrollment in Medicaid at first contact. Intake process not customer focused. Geographical access issues. Lack of marketing and education about services. Slow and often unsuccessful transitions across system

Priority #: 4

Priority Area: Increase outpatient substance use disorder treatment for adults

Priority Type: SAT

Population(s): PWWDC, IVDUs (LGBTQ, Rural, Military Families, Criminal/Juvenile Justice, Persons with Disablities, Underserved Racial and Ethnic Minorities)

Goal of the priority area:

Increase percentage of outpatient substance use disorder treatment retention in adults from 68.7% to 70.7%.

Objective:

Strategies to attain the objective:

Explore new mechanism and protocols for case management and continue using Performance Based Contracting to improve retention in Adult Outpatient, increase contracted target and add technical assistance tools for use by providers

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Adult CD Outpatient Caseload & Adult Outpatient Treatment Retention by Governing County

Baseline Measurement:

First-year target/outcome measurement: Workgroup to review identified countermeasures for feasibility and potential impact

Second-year target/outcome measurement: Convene internal workgroup to establish timeline, implementation plan, and actual products for implementation

Data Source:

SCOPE/TARGET/Treatment Analyzer

Description of Data:

"SFY2013 Served" is an unduplicated count of adults (persons 18 years of age and older) served in publically-funded outpatient treatment or Opiate Substitution Treatment between July 1, 2012 and June 30, 2013.

Data issues/caveats that affect outcome measures::

Lack of case management ability by the treatment programs for issues such as client engagement, money for transportation and assistance to get into supportive housing. Adult outpatient clients not currently being retained at the rate that is set above

Priority #: 5

Priority Area: Decrease homelessness for mental health consumers

Priority Type: MHS

Population(s): SMI, SED (Rural, Homeless, Underserved Racial and Ethnic Minorities)

Goal of the priority area:

Decrease number of homeless people from 17,775 to 16,000 (10% reduction)

Objective:

Strategies to attain the objective:

Washington will build upon the chronic homeless policy academy and strategic planning processes as well as national technical assistance received through SAMHSA and HUD to facilitate and develop stronger relationships and agreements with state and local housing, community development agencies and HUD over the next year. Pilot projects and grant-funded projects in Washington State have demonstrated the need for, as well as, the success of supportive housing services. Replication and dissemination of the service model would continue. Data collection and outcome evaluation as well as facilitating stronger relationships with proprietors of affordable housing stock and community room and board resources will be implemented through policy academy workgroups, webinars and conference presentations.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Align annual performance indicators and performance measurements with Engrossed House Bill 1519 and Second Substitute Senate Bill 5732 (2013).

Baseline Measurement: Homelessness/housing instability (broad)

First-year target/outcome measurement: Increased awareness and fidelity to EBP PSH model

Second-year target/outcome measurement: Development of baseline measurement and contractual benchmarks

Data Source:

ACES, HMIS, and medical/behavioral health data systems

Description of Data:

Number and percent of clients with any identified homelessness or housing instability in any of five data systems

Data issues/caveats that affect outcome measures::

The 1115-5732 workgroup sought to align housing measures with homelessness measures used by other systems such as the U.S. Department of Housing and Urban Development (HUD), the Washington State Department of Commerce, and local housing providers. Three separate populations sought for measurement included: individuals living in places not meant for housing (such as the street, tents, or cars), individuals homeless but sheltered (such as in emergency shelters), and individuals at risk of homelessness (such as those staying temporarily with friends or family members).
Special focus was paid to the need to identify housing and residential measures appropriate for long-term care clients. After much discussion and additional analyses of proposed measures, this was accomplished through a measure included in the HWUD workgroup's recommended measures: for Home- and Community-Based Long Term Services and Supports Use, the proportion of person-months receiving long-term services and supports associated with receipt of services in home- and community-based settings during the measurement year. Additionally, as the housing measures go forward, the state must guard against the use of institutions (nursing facilities, state psychiatric hospitals) as a method to reduce housing instability

Priority #: 6

Priority Area: Increase outpatient mental health services for youth

Priority Type: MHS

Population(s): SED (Adolescents w/SA and/or MH, Underserved Racial and Ethnic Minorities)

Goal of the priority area:

Increase the number of youth receiving outpatient mental health services

Objective:

Strategies to attain the objective:

Increase the use of wraparound community based mental health services and supports. Enhance transition planning to reduce inpatient utilization

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The number of youth receiving outpatient mental health services will increase each quarter while maintaining or decreasing inpatient utilization

Baseline Measurement: Third quarter FY13 average of 23,000

First-year target/outcome measurement: Implementation of Wraparound with Intensive Services (WISe)

Second-year target/outcome measurement: Implement the use of CANS

Data Source:

Mental Health Consumer Information System (CIS), via the System for Communicating Outcomes, Performance and Evaluation (SCOPE-WA)

Description of Data:

Number of Medicaid and Non-Medicaid youth (under age 18) receiving (1) outpatient mental health services and (2) inpatient (i.e., Community Hospital Psychiatric Unit services or Evaluation and Treatment [E&T] Center) services from RSNs; and (3) inpatient services from the Child Study and Treatment Center (CSTC) and the Children's Long-Term Inpatient Program (CLIP).

Data issues/caveats that affect outcome measures::

Wraparound services not available statewide and lack of uniformity on acute care policy and utilization

Priority #: 7

Priority Area: Increase employment and earning for clients

Priority Type: SAP

Population(s): PWWDC, IVDUs (Underserved Racial and Ethnic Minorities)

Goal of the priority area:

Increase rates of employment and earnings for that receiving BHSIA-funded substance use disorder treatment.

Objective:

Strategies to attain the objective:

Indisputable evidence of the beneficial effects of evidence based supported employment coupled with the clearly delineated deleterious effects of long term unemployment offers strong fiscal and therapeutic rationales for a targeted supported employment services. Washington has been chosen to participate in a SAMHSA sponsored Olmstead policy academy to improve employment outcomes for individuals with behavioral health disabilities as well as the Dartmouth Psychiatric Research Center's Supported Employment Learning Collaborative. Supported employment pilot projects and grant-funded projects are currently underway in Washington State and will assist in scaling and replicating supported employment services. Fidelity review processes will be established utilizing national learning collaborative models through the Dartmouth Psychiatric Research Center. •Stakeholder education and training: Through a federally funded SAMHSA grant, training on evidence-based practice Supported Employment also known as the

Individual Placement and Support model will be provided to BHOs and provider agencies. Workforce education on the negative impact of long-term unemployment on individual's mental and physical health will be provided through federal grant resources including to BHO personnel, and the provider community. Stakeholder education and anti-stigma campaigns for employers will be held. • Modify IT systems: The state will develop clearly defined and consistently reported data regarding employment and spending for participants. •Client Outreach and education: Inclusion of the supported employment service will be included in benefit booklets, postcards or other marketing devices to promote it to clients as well as including webinars open to the public to publicize the supportive employment service availability. Information will also include dissemination of the Washington Medicaid Buy-In program called Healthcare for Workers with Disabilities which has demonstrated achieving greater self-sufficiency while obtaining comprehensive health care and benefits needed by workers with disabilities.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	1115-5732 Measurement – Employment Rate: Number and percent of clients with any earning in the quarter of service
Baseline Measurement:	Employment Rate: Number and percent of clients with any earning in the quarter of service
First-year target/outcome measurement:	Increased awareness and fidelity to EBP SE model
Second-year target/outcome measurement:	Development of baseline measurement and contractual benchmarks

Data Source:

Development of baseline measurement and contractual benchmarks

Description of Data:

CIS and TARGET data crossed with Employer-reported earnings and hours data collected by the Washington State Employment Security Department on quarterly basis.

Data issues/caveats that affect outcome measures::

CIS and TARGET data crossed with Employer-reported earnings and hours data collected by the Washington State Employment Security Department on quarterly basis

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [SA]

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Activity	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention* and Treatment	$0		$0	$0	$0	$0	$0
a. Pregnant Women and Women with Dependent Children*	$0		$0	$0	$0	$0	$0
b. All Other	$0		$0	$0	$0	$0	$0
2. Substance Abuse Primary Prevention	$0		$0	$0	$0	$0	$0
3. Tuberculosis Services	$0		$0	$0	$0	$0	$0
4. HIV Early Intervention Services	$0		$0	$0	$0	$0	$0
5. State Hospital							
6. Other 24 Hour Care							
7. Ambulatory/Community Non-24 Hour Care							
8. Mental Health Primary Prevention**							
9. Evidenced Based Practices for Early Intervention (5% of the state's total MHBG award)							
10. Administration (Excluding Program and Provider Level)	$0		$0	$0	$0	$0	$0
13. Total	$0	$0	$0	$0	$0	$0	$0

* Prevention other than primary prevention

** It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [MH]

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Activity	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention* and Treatment							
a. Pregnant Women and Women with Dependent Children*							
b. All Other							
2. Substance Abuse Primary Prevention							
3. Tuberculosis Services							
4. HIV Early Intervention Services							
5. State Hospital			$0	$0	$0	$0	$0
6. Other 24 Hour Care		$0	$0	$0	$0	$0	$0
7. Ambulatory/Community Non-24 Hour Care		$0	$0	$0	$0	$0	$0
8. Mental Health Primary Prevention**		$0	$0	$0	$0	$0	$0
9. Evidenced Based Practices for Early Intervention (5% of the state's total MHBG award)		$0	$0	$0	$0	$0	$0
10. Administration (Excluding Program and Provider Level)		$0	$0	$0	$0	$0	$0
13. Total	$0	$0	$0	$0	$0	$0	$0

* Prevention other than primary prevention

** It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

Footnotes:

Planning Tables

Table 3 State Agency Planned Block Grant Expenditures by Service

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Service	SABG Expenditures	MHBG Expenditures
Healthcare Home/Physical Health	$	$
General and specialized outpatient medical services;		
Acute Primary Care;		
General Health Screens, Tests and Immunizations;		
Comprehensive Care Management;		
Care coordination and Health Promotion;		
Comprehensive Transitional Care;		
Individual and Family Support;		
Referral to Community Services;		
Prevention Including Promotion	$	$

Screening, Brief Intervention and Referral to Treatment ;		
Brief Motivational Interviews;		
Screening and Brief Intervention for Tobacco Cessation;		
Parent Training;		
Facilitated Referrals;		
Relapse Prevention/Wellness Recovery Support;		
Warm Line;		
Substance Abuse Primary Prevention	$	$
Classroom and/or small group sessions (Education);		
Media campaigns (Information Dissemination);		
Systematic Planning/Coalition and Community Team Building(Community Based Process);		
Parenting and family management (Education);		
Education programs for youth groups (Education);		
Community Service Activities (Alternatives);		
Student Assistance Programs (Problem Identification and Referral);		

Employee Assistance programs (Problem Identification and Referral);		
Community Team Building (Community Based Process);		
Promoting the establishment or review of alcohol, tobacco, and drug use policies (Environmental);		
Engagement Services	$	$
Assessment;		
Specialized Evaluations (Psychological and Neurological);		
Service Planning (including crisis planning);		
Consumer/Family Education;		
Outreach;		
Outpatient Services	$	$
Individual evidenced based therapies;		
Group Therapy;		
Family Therapy ;		
Multi-family Therapy;		

Consultation to Caregivers;		
Medication Services	$	$
Medication Management;		
Pharmacotherapy (including MAT);		
Laboratory services;		
Community Support (Rehabilitative)	$	$
Parent/Caregiver Support;		
Skill Building (social, daily living, cognitive);		
Case Management;		
Behavior Management;		
Supported Employment;		
Permanent Supported Housing;		
Recovery Housing;		
Therapeutic Mentoring;		
Traditional Healing Services;		

Recovery Supports	$	$
Peer Support;		
Recovery Support Coaching;		
Recovery Support Center Services;		
Supports for Self-directed Care;		
Other Supports (Habilitative)	$	$
Personal Care;		
Homemaker;		
Respite;		
Supported Education;		
Transportation;		
Assisted Living Services;		
Recreational Services;		
Trained Behavioral Health Interpreters;		

Interactive Communication Technology Devices;		
Intensive Support Services	$	$
Substance Abuse Intensive Outpatient (IOP);		
Partial Hospital;		
Assertive Community Treatment;		
Intensive Home-based Services;		
Multi-systemic Therapy;		
Intensive Case Management ;		
Out-of-Home Residential Services	$	$
Crisis Residential/Stabilization;		
Clinically Managed 24 Hour Care (SA);		
Clinically Managed Medium Intensity Care (SA) ;		
Adult Mental Health Residential ;		
Youth Substance Abuse Residential Services;		
Children's Residential Mental Health Services ;		

Therapeutic Foster Care;		
Acute Intensive Services	$	$
Mobile Crisis;		
Peer-based Crisis Services;		
Urgent Care;		
23-hour Observation Bed;		
Medically Monitored Intensive Inpatient (SA);		
24/7 Crisis Hotline Services;		
Other	$	$
Total	$0	$0

Footnotes:

Planning Tables

Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Expenditure Category	FY 2016 SA Block Grant Award
1 . Substance Abuse Prevention* and Treatment	$26,853,254
2 . Substance Abuse Primary Prevention	$8,578,123
3 . Tuberculosis Services	
4 . HIV Early Intervention Services**	
5 . Administration (SSA Level Only)	$1,864,809
6. Total	$37,296,186

* Prevention other than primary prevention

** 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant; Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by CDC, National Center for HIV/AIDS, Hepatitis, STD and TB Prevention. The HIV Surveillance Report, Volume 24, will be used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective FY 2016 SABG allotments to establish one or more projects to provide early intervention services for HIV at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a "designated state" in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state does not meet the AIDS case rate threshold for the fiscal year involved. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance would be allowed to obligate and expend FY 2016 SABG funds for EIS/HIV if they chose to do so.

Footnotes:

Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Strategy	IOM Target	FY 2016
		SA Block Grant Award
Information Dissemination	Universal	$93,000
	Selective	$1,016
	Indicated	
	Unspecified	
	Total	$94,016
Education	Universal	$1,263,057
	Selective	$158,048
	Indicated	$15,631
	Unspecified	
	Total	$1,436,736
Alternatives	Universal	$868,969
	Selective	$304,670
	Indicated	$218
	Unspecified	
	Total	$1,173,856
Problem Identification and Referral	Universal	$1,706
	Selective	$187,959
	Indicated	$4,032,405
	Unspecified	
	Total	$4,222,070

Community-Based Process	Universal	$855,435
	Selective	$23,595
	Indicated	$2,033
	Unspecified	
	Total	$881,062
Environmental	Universal	$85,304
	Selective	
	Indicated	
	Unspecified	
	Total	$85,304
Section 1926 Tobacco	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	
Other	Universal	
	Selective	
	Indicated	
	Unspecified	$685,079
	Total	$685,079
Total Prevention Expenditures		$8,578,123
Total SABG Award*		$37,296,186
Planned Primary Prevention Percentage		23.00 %

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

Footnotes:

Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Activity	FY 2016 SA Block Grant Award	
Universal Direct	$3,167,470	
Universal Indirect	$685,079	
Selective	$675,288	
Indicated	$4,050,286	
Column Total	$8,578,123	
Total SABG Award*	$37,296,186	
Planned Primary Prevention Percentage	23.00 %	

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

Footnotes:

Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Targeted Substances	
Alcohol	
Tobacco	
Marijuana	
Prescription Drugs	
Cocaine	
Heroin	
Inhalants	
Methamphetamine	
Synthetic Drugs (i.e. Bath salts, Spice, K2)	
Targeted Populations	
Students in College	
Military Families	
LGBT	
American Indians/Alaska Natives	
African American	
Hispanic	
Homeless	
Native Hawaiian/Other Pacific Islanders	
Asian	
Rural	
Underserved Racial and Ethnic Minorities	

Footnotes:

Planning Tables

Table 6a SABG Resource Development Activities Planned Expenditures

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Activity	FY 2016 SA Block Grant Award			
	Prevention	Treatment	Combined	Total
1. Planning, Coordination and Needs Assessment	$0	$0	$0	
2. Quality Assurance	$0	$0	$0	
3. Training (Post-Employment)	$189,969	$0	$0	$189,969
4. Education (Pre-Employment)	$0	$0	$0	
5. Program Development	$206,843	$132,682	$0	$339,525
6. Research and Evaluation	$11,281	$118,069	$0	$129,350
7. Information Systems	$200,364	$9,267	$0	$209,631
8. Total	$608,457	$260,018		$868,475

Footnotes:

Planning Tables

Table 6b MHBG Non-Direct Service Activities Planned Expenditures

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Service	Block Grant
MHA Technical Assistance Activities	
MHA Planning Council Activities	
MHA Administration	
MHA Data Collection/Reporting	
MHA Activities Other Than Those Above	
Total Non-Direct Services	$0

Comments on Data:

Footnotes:

Environmental Factors and Plan

1. The Health Care System and Integration

Narrative Question:

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.[26] Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but “[h]ealth system factors” such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.[27] It has been acknowledged that there is a high rate of co- occurring mental illness and substance abuse, with appropriate treatment required for both conditions.[28] Overall, America has reduced its heart disease risk based on lessons from a 50-year research project on the town of Framingham, MA, outside Boston, where researchers followed thousands of residents to help understand what causes heart disease. The Framingham Heart Study produced the idea of "risk factors" and helped to make many connections for predicting and preventing heart disease.

There are five major preventable risks identified in the Framingham Heart Study that may impact people who live with mental illness. These risks are smoking, obesity, diabetes, elevated cholesterol, and hypertension. These risk factors can be appropriately modified by implementing well-known evidence–based practices[29] [30] that will ensure a higher quality of life.

Currently, 50 states have organizationally consolidated their mental and substance abuse authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.[31] Specific to children, many children and youth with mental illness and substance use issues are more likely to be seen in a health care setting than in the specialty mental health and substance abuse system. In addition, children with chronic medical conditions have more than two times the likelihood of having a mental disorder. In the U.S., more than 50 percent of adults with mental illness had symptoms by age 14, and three-fourths by age 24. It is important to address the full range of needs of children, youth and adults through integrated health care approaches across prevention, early identification, treatment, and recovery.

It is vital that SMHAs' and SSAs' programming and planning reflect the strong connection between behavioral, physical and population/public health, with careful consideration to maximizing impact across multiple payers including Medicaid, exchange products, and commercial coverages. Behavioral health disorders are true physical disorders that often exhibit diagnostic criteria through behavior and patient reports rather than biomarkers. Fragmented or discontinuous care may result in inadequate diagnosis and treatment of both physical and behavioral conditions, including co-occurring disorders. For instance, persons receiving behavioral health treatment may be at risk for developing diabetes and experiencing complications if not provided the full range of necessary care.[32] In some cases, unrecognized or undertreated physical conditions may exacerbate or cause psychiatric conditions.[33] Persons with physical conditions may have unrecognized mental challenges or be at increased risk for such challenges.[34] Some patients may seek to self-medicate due to their chronic physical pain or become addicted to prescribed medications or illicit drugs.[35] In all these and many other ways, an individual's mental and physical health are inextricably linked and so too must their health care be integrated and coordinated among providers and programs.

Health care professionals and consumers of mental illness and substance abuse treatment recognize the need for improved coordination of care and integration of physical and behavioral health with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.[36]

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.[37] Strategies supported by SAMHSA to foster integration of physical and behavioral health include: developing models for inclusion of behavioral health treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between mental and substance abuse treatment providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as federally qualified health centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including electronic health records (EHRs) and telehealth are examples of important strategies to promote integrated care.[38] Use of EHRs – in full compliance with applicable legal requirements – may allow providers to share information, coordinate care and improve billing practices. Telehealth is another important tool that may allow behavioral health prevention, care, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes[39] and ACOs[40] may be important strategies used by SMHAs and SSAs to foster integrated care. Training and assisting behavioral health providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes.

The Affordable Care Act is an important part of efforts to ensure access to care and better integrate care. Non-grandfathered health plans sold in the individual or the small group health insurance markets offered coverage for mental and substance use disorders as an essential health benefit.

SSAs and SMHAs also may work with Medicaid programs and Insurance Commissioners to encourage development of innovative demonstration projects and waivers that test approaches to providing integrated care for persons with mental illness and substance use disorders and other vulnerable populations.[41] Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.[42]

One key population of concern is persons who are dually eligible for Medicare and Medicaid.[43] Roughly, 30 percent of dually eligible persons have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.[44] SMHAs and SSAs also should collaborate with Medicaid, insurers and insurance regulators to develop policies to assist those individuals who experience health coverage eligibility changes due to shifts in income and employment.[45] Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with behavioral health conditions still may experience challenges in some areas in obtaining care for a particular condition or finding a provider.[46] SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of behavioral health conditions and work with partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.

SMHAs and SSAs should ensure access and integrated prevention care and recovery support in all vulnerable populations including, but not limited to college students and transition age youth (especially those at risk of first episodes of mental illness or substance abuse); American Indian/Alaskan Natives; ethnic minorities experiencing health and behavioral health disparities; military families; and, LGBT individuals. SMHAs and SSAs should discuss with Medicaid and other partners, gaps that may exist in services in the post-Affordable Care Act environment and the best uses of block grant funds to fill such gaps. SMHAs and SSAs should work with Medicaid and other stakeholders to facilitate reimbursement for evidence-based and promising practices.[47] It also is important to note CMS has indicated its support for incorporation within Medicaid programs of such approaches as peer support (under the supervision of mental health professionals) and trauma-informed treatment and systems of care. Such practices may play an important role in facilitating integrated, holistic care for adults and children with behavioral health conditions.[48]

SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.[49] Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists and others will need to understand integrated care models, concepts and practices.

Another key part of integration will be defining performance and outcome measures. Following the Affordable Care Act, the Department of Health and Human Services (HHS) and partners have developed the NQS, which includes information and resources to help promote health, good outcomes and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.[50]

SAMHSA recognizes that certain jurisdictions receiving block grant funds – including U.S. Territories, tribal entities and those jurisdictions that have signed compacts of free association with the U.S. – may be uniquely impacted by certain Affordable Care Act and Medicaid provisions or ineligible to participate in certain programs.[51] However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment and recovery support for persons with, or at risk of, mental illnesses and substance use disorders.

Numerous provisions in the Affordable Care Act and other statutes improve the coordination of care for patients through the creation of health homes, where teams of health care professionals will be charged with coordinating care for patients with chronic conditions. States that have approved Medicaid State Plan Amendments (SPAs) will receive 90 percent Federal Medical Assistance Percentage (FMAP) for health home services for eight quarters. At this critical juncture, some states are ending their two years of enhanced FMAP and returning to their regular state FMAP for health home services. In addition, many states may be a year into the implementation of their dual eligible demonstration projects.

Please consider the following items as a guide when preparing the description of the healthcare system and integration within the state's system:

1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs as of January 1, 2016?
2. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?
3. Who is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe the monitoring process.
4. Will the SMHA and/or SSA be involved in reviewing any complaints or possible violations or MHPAEA?
5. What specific changes will the state make in consideration of the coverage offered in the state's EHB package?
6. Is the SSA/SMHA is involved in the various coordinated care initiatives in the state?
7. Is the SSA/SMHA work with the state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHCs), other primary care practices, and the publicly funded behavioral health providers?
8. Are state behavioral health facilities moving towards addressing nicotine dependence on par with other substance use disorders?
9. What agency/system regularly screens, assesses, and addresses smoking among persons served in the behavioral health system?

10. Indicate tools and strategies used that support efforts to address nicotine cessation.
    - Regular screening with a carbon monoxide (CO) monitor
    - Smoking cessation classes
    - Quit Helplines/Peer supports
    - Others_____
11. The behavioral health providers screen and refer for:
    - Prevention and wellness education;
    - Health risks such as heart disease, hypertension, high cholesterol, and/or diabetes; and,
    - Recovery supports

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

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[26] BG Druss et al. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Med Care. 2011 Jun;49(6):599-604; Bradley Mathers, Mortality among people who inject drugs: a systematic review and meta-analysis, Bulletin of the World Health Organization, 2013;91:102–123

http://www.who.int/bulletin/volumes/91/2/12-108282.pdf; MD Hert et al., Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care, World Psychiatry. Feb 2011; 10(1): 52–77

[27] Research Review of Health Promotion Programs for People with SMI, 2012, http://www.integration.samhsa.gov/health-wellness/wellnesswhitepaper; About SAMHSA's Wellness Efforts,

http://www.promoteacceptance.samhsa.gov/10by10/default.aspx; JW Newcomer and CH Hennekens, Severe Mental Illness and Risk of Cardiovascular Disease, JAMA; 2007; 298: 1794-1796; Million Hearts, http://www.integration.samhsa.gov/health-wellness/samhsa-10x10 Schizophrenia as a health disparity, http://www.nimh.nih.gov/about/director/2013/schizophrenia-as-a-health-disparity.shtml

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

[29] 2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults: Report From the Panel Members Appointed to the Eighth Joint National Committee (JNC 8); JAMA. 2014;311(5):507-520.doi:10.1001/jama.2013.284427

[30] A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines: 2013 ACC/AHA Guideline on the Assessment of Cardiovascular Risk; http://circ.ahajournals.org/

[31] Social Determinants of Health, Healthy People 2020, http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39;

http://www.cdc.gov/socialdeterminants/Index.html

[32] Depression and Diabetes, NIMH, http://www.nimh.nih.gov/health/publications/depression-and-diabetes/index.shtml#pub5;Diabetes Care for Clients in Behavioral health Treatment, Oct. 2013, SAMHSA, http://store.samhsa.gov/product/Diabetes-Care-for-Clients-in-Behavioral-Health-Treatment/SMA13-4780

[33] J Pollock et al., Mental Disorder or Medical Disorder? Clues for Differential Diagnosis and Treatment Planning, Journal of Clinical Psychology Practice, 2011 (2) 33-40

[34] C. Li et al., Undertreatment of Mental Health Problems in Adults With Diagnosed Diabetes and Serious Psychological Distress, Diabetes Care, 2010; 33(5) 1061-1064

[35] TIP 54: Managing Chronic Pain in Adults With or in Recovery From Substance Use Disorders, SAMHSA, 2012, http://store.samhsa.gov/product/TIP-54-Managing-Chronic-Pain-in-Adults-With-or-in-Recovery-From-Substance-Use-Disorders/SMA13-4671

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

http://www.nami.org/Content/NavigationMenu/State_Advocacy/About_the_Issue/Integration_MH_And_Primary_Care_2011.pdf;. Abrams, Michael T. (2012, August 30). *Coordination of care for persons with substance use disorders under the Affordable Care Act: Opportunities and challenges.* Baltimore, MD: The Hilltop Institute, UMBC.

http://www.hilltopinstitute.org/publications/CoordinationOfCareForPersonsWithSUDSUnderTheACA-August2012.pdf; Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes, American Hospital Association, Jan. 2012, http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf; American Psychiatric Association, http://www.psych.org/practice/professional-interests/integrated-care; Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series (2006), Institute of Medicine, National Affordable Care Academy of Sciences, http://books.nap.edu/openbook.php?record_id=11470&page=210; State Substance Abuse Agency and Substance Abuse Program Efforts Towards Healthcare Integration: An Environmental Scan, National Association of State Alcohol/Drug Abuse Directors, 2011, http://nasadad.org/nasadad-reports

[37] Health Care Integration, http://samhsa.gov/health-reform/health-care-integration; SAMHSA-HRSA Center for Integrated Health Solutions, (http://www.integration.samhsa.gov/)

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

[39] Health homes, http://www.integration.samhsa.gov/integrated-care-models/health-homes

[40] New financing models, http://www.samhsa.gov/co-occurring/topics/primary-care/financing_final.aspx

[41] Waivers, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html;Coverage and Service Design Opportunities for Individuals with Mental Illness and Substance Use Disorders, CMS

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

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

[44] Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies, CBO, June 2013, http://www.cbo.gov/publication/44308

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

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

[47] http://www.nrepp.samhsa.gov/

[48] Clarifying Guidance on Peer Support Services Policy, May 2013, CMS, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/Clarifying-Guidance-Support-Policy.pdf; Peer Support Services for Adults with Mental Illness and/or Substance Use Disorder, August 2007, http://www.medicaid.gov/Federal-Policy-guidance/federal-policy-guidance.html; Tri-Agency Letter on Trauma-Informed Treatment, July 2013, http://medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-07-11.pdf

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

[50] About the National Quality Strategy, http://www.ahrq.gov/workingforquality/about.htm; National Behavioral Health Quality Framework, Draft, August 2013, http://samhsa.gov/data/NBHQF

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Not Required

Environmental Factors and Plan

2. Health Disparities

Narrative Question:

In accordance with the *HHS Action Plan to Reduce Racial and Ethnic Health Disparities*[52], *Healthy People, 2020*[53], *National Stakeholder Strategy for Achieving Health Equity*[54], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and behavioral health outcomes among individuals of all cultures and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, and people living with HIV/AIDS or other chronic diseases/impairments) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS standards).[55]

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

The top Secretarial priority in the Action Plan is to "[a]ssess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."[56]

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, in accordance with section 4302 of the Affordable Care Act, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status.[57] This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations.[58] In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBT populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide behavioral health services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

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

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is being served or not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations, which can be defined by the following factors: race, ethnicity, language, gender (including transgender), tribal connection, and sexual orientation (i.e., lesbian, gay, bisexual).

Please consider the following items as a guide when preparing the description of the healthcare system and integration within the state's system:

1. Does the state track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBT, and age?
2. Describe the state plan to address and reduce disparities in access, service use, and outcomes for the above subpopulations.
3. Are linguistic disparities/language barriers identified, monitored, and addressed?
4. Describe provisions of language assistance services that are made available to clients served in the behavioral health provider system.
5. Is there state support for cultural and linguistic competency training for providers?

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

[52] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

[53] http://www.healthypeople.gov/2020/default.aspx

[54] http://minorityhealth.hhs.gov/npa/files/Plans/NSS/NSSExecSum.pdf

[55] http://www.ThinkCulturalHealth.hhs.gov

[56] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

[57] http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=208

[58] http://www.whitehouse.gov/omb/fedreg_race-ethnicity

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

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

Addressing the Needs of Racial, Ethnic and Sexual Minorities
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.

Environmental Factors and Plan

3. Use of Evidence in Purchasing Decisions

Narrative Question:

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

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. Since 2001, SAMHSA has sponsored a National Registry of Evidenced-based Programs and Practices (NREPP). NREPP[59] is a voluntary, searchable online registry of more than 220 submitted interventions supporting mental health promotion and treatment and substance abuse prevention and treatment. The purpose of NREPP is to connect members of the public to intervention developers so that they can learn how to implement these approaches in their communities. NREPP is not intended to be an exhaustive listing of all evidence-based practices in existence.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with (SED). The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General[60], The New Freedom Commission on Mental Health[61], the IOM[62], and the NQF.[63] The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."[64] SAMHSA and other federal partners (the Administration for Children and Families (ACF), the HHS Office of Civil Rights (OCR), and CMS) have used this information to sponsor technical expert panels that provide specific recommendations to the behavioral health field regarding what the evidence indicates works and for whom, identify specific strategies for embedding these practices in provider organizations, and recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. These are services that have not been studied, but anecdotal evidence and program specific data indicate that they are effective. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocols (TIPs)[65] are best practice guidelines for the treatment of substance abuse. The Center for Substance Abuse Treatment (CSAT) draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPs, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPs is expanding beyond public and private substance abuse treatment facilities as alcohol and other drug disorders are increasingly recognized as a major problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation (KIT)[66] was developed to help move the latest information available on effective behavioral health practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement behavioral health practices that work. KIT, part of SAMHSA's priority initiative on Behavioral Health Workforce in Primary and Specialty Care Settings, covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

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

Please consider the following items as a guide when preparing the description of the state's system:

1. Describe the specific staff responsible for tracking and disseminating information regarding evidence-based or promising practices.
2. How is information used regarding evidence-based or promising practices in your purchasing or policy decisions?
3. Are the SMAs and other purchasers educated on what information is used to make purchasing decisions?
4. Does the state use a rigorous evaluation process to assess emerging and promising practices?
5. Which value based purchasing strategies do you use in your state:
    a. Leadership support, including investment of human and financial resources.
    b. Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
    c. Use of financial incentives to drive quality.

d. Provider involvement in planning value-based purchasing.

e. Gained consensus on the use of accurate and reliable measures of quality.

f. Quality measures focus on consumer outcomes rather than care processes.

g. Development of strategies to educate consumers and empower them to select quality services.

h. Creation of a corporate culture that makes quality a priority across the entire state infrastructure.

i. The state has an evaluation plan to assess the impact of its purchasing decisions.

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

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[59] Ibid, 47, p. 41

[60] United States Public Health Service Office of the Surgeon General (1999). Mental Health: A Report of the Surgeon General. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

[61] The President's New Freedom Commission on Mental Health (July 2003). Achieving the Promise: Transforming Mental Health Care in America. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

[62] Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders (2006). Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. Washington, DC: National Academies Press.

[63] National Quality Forum (2007). National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices. Washington, DC: National Quality Forum.

[64] http://psychiatryonline.org/

[65] http://store.samhsa.gov

[66] http://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4345

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Not Required

4. Prevention for Serious Mental Illness

Narrative Question:

SMIs such as schizophrenia, psychotic mood disorders, bipolar disorders and others produce significant psychosocial and economic challenges. Prior to the first episode, a large majority of individuals with psychotic illnesses display sub-threshold or early signs of psychosis during adolescence and transition to adulthood.[67] The "Prodromal Period" is the time during which a disease process has begun but has not yet clinically manifested. In the case of psychotic disorders, this is often described as a prolonged period of attenuated and nonspecific thought, mood, and perceptual disturbances accompanied by poor psychosocial functioning, which has historically been identified retrospectively. Clinical High Risk (CHR) or At-Risk Mental State (ARMS) are prospective terms used to identify individuals who might be potentially in the prodromal phase of psychosis. While the MHBG must be directed toward adults with SMI or children with SED, including early intervention after the first psychiatric episode, states may want to consider using other funds for these emerging practices.

There has been increasing neurobiological and clinical research examining the period before the first psychotic episode in order to understand and develop interventions to prevent the first episode. There is a growing body of evidence supporting preemptive interventions that are successful in preventing the first episode of psychosis. The National Institute for Mental Health (NIMH) funded the North American Prodromal Longitudinal study (NAPLS), which is a consortium of eight research groups that have been working to create the evidence base for early detection and intervention for prodromal symptoms. Additionally, the Early Detection and Intervention for the Prevention of Psychosis (EDIPP) program, funded by the Robert Wood Johnson Foundation, successfully broadened the Portland Identification and Early Referral (PIER) program from Portland, Maine, to five other sites across the country. SAMHSA supports the development and implementation of these promising practices for the early detection and intervention of individuals at Clinical High Risk for psychosis, and states may want to consider how these developing practices may fit within their system of care. Without intervention, the transition rate to psychosis for these individuals is 18 percent after 6 months of follow up, 22 percent after one year, 29 percent after two years, and 36 percent after three years. With intervention, the risk of transition to psychosis is reduced by 54 percent at a one-year follow up.[68] In addition to increased symptom severity and poorer functioning, lower employment rates and higher rates of substance use and overall greater disability rates are more prevalent.[69] The array of services that have been shown to be successful in preventing the first episode of psychosis include accurate clinical identification of high-risk individuals; continued monitoring and appraisal of psychotic and mood symptoms and identification; intervention for substance use, suicidality and high risk behaviors; psycho-education; family involvement; vocational support; and psychotherapeutic techniques.[70] [71] This reflects the critical importance of early identification and intervention as there is a high cost associated with delayed treatment.

Overall, the goal of early identification and treatment of young people at high clinical risk, or in the early stages of mental disorders with psychosis is to: (1) alter the course of the illness; (2) reduce disability; and, (3) maximize recovery.

****It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

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

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[67] Larson, M.K., Walker, E.F., Compton, M.T. (2010). Early signs, diagnosis and therapeutics of the prodromal phase of schizophrenia and related psychotic disorders. Expert Rev Neurother. Aug 10(8):1347-1359.

[68] Fusar-Poli, P., Bonoldi, I., Yung, A.R., Borgwardt, S., Kempton, M.J., Valmaggia, L., Barale, F., Caverzasi, E., & McGuire, P. (2012). Predicting psychosis: meta-analysis of transition outcomes in individuals at high clinical risk. Arch Gen Psychiatry. 2012 March 69(3):220-229.

[69] Whiteford, H.A., Degenhardt, L., Rehm, J., Baxter, A.J., Ferrari, A.J., Erskine, H.E., Charlson, F.J., Norman, R.E., Flaxman, A.D., Johns, N., Burstein, R., Murray, C.J., & Vos T. (2013). Global burden of disease attributable to mental and substance use disorders: findings from the Global Burden of Disease Study 2010. Lancet. Nov 9;382(9904):1575-1586.

[70] van der Gaag, M., Smit, F., Bechdolf, A., French, P., Linszen, D.H., Yung, A.R., McGorry, P., & Cuijpers, P. (2013). Preventing a first episode of psychosis: meta-analysis of randomized controlled prevention trials of 12-month and longer-term follow-ups. Schizophr Res. Sep;149(1-3):56-62.

[71] McGorry, P., Nelson, B., Phillips, L.J., Yuen, H.P., Francey, S.M., Thampi, A., Berger, G.E., Amminger, G.P., Simmons, M.B., Kelly, D., Dip, G., Thompson, A.D., & Yung, A.R. (2013). Randomized controlled trial of interventions for young people at ultra-high risk of psychosis: 12-month outcome. J Clin Psychiatry. Apr;74(4):349-56.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Not Required

Environmental Factors and Plan

5 Evidence-Based Practices for Early Intervention (5 percent set-aside)

Narrative Question:

P.L. 113-76 and P.L. 113-235 requires that states set aside five percent of their MHBG allocation to support evidence-based programs that provide treatment to those with early SMI including but not limited to psychosis at any age.[72] SAMHSA worked collaboratively with the NIMH to review evidence-showing efficacy of specific practices in ameliorating SMI and promoting improved functioning. NIMH has released information on Components of Coordinated Specialty Care (CSC) for First Episode Psychosis. Results from the NIMH funded Recovery After an Initial Schizophrenia Episode (RAISE) initiative[73], a research project of the NIMH, suggest that mental health providers across multiple disciplines can learn the principles of CSC for First Episode of Psychosis (FEP), and apply these skills to engage and treat persons in the early stages of psychotic illness. At its core, CSC is a collaborative, recovery-oriented approach involving clients, treatment team members, and when appropriate, relatives, as active participants. The CSC components emphasize outreach, low-dosage medications, evidenced-based supported employment and supported education, case management, and family psycho-education. It also emphasizes shared decision-making as a means to address individuals' with FEP unique needs, preferences, and recovery goals. Collaborative treatment planning in CSC is a respectful and effective means for establishing a positive therapeutic alliance and maintaining engagement with clients and their family members over time. Peer supports can also be an enhancement on this model. Many also braid funding from several sources to expand service capacity.

States can implement models across a continuum that have demonstrated efficacy, including the range of services and principles identified by NIMH. Using these principles, regardless of the amount of investment, and with leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, every state will be able to begin to move their system toward earlier intervention, or enhance the services already being implemented.

It is expected that the states' capacity to implement this programming will vary based on the actual funding from the five percent allocation. SAMHSA continues to provide additional technical assistance and guidance on the expectations for data collection and reporting.

Please provide the following information, updating the State's 5% set-aside plan for early intervention:

1. An updated description of the states chosen evidence-based practice for early intervention (5% set-aside initiative) that was approved in its 2014 plan.
2. An updated description of the plan's implementation status, accomplishments and/ any changes in the plan.
3. The planned activities for 2016 and 2017, including priorities, goals, objectives, implementation strategies, performance indicators, and baseline measures.
4. A budget showing how the set-aside and additional state or other supported funds, if any, for this purpose.
5. The states provision for collecting and reporting data, demonstrating the impact of this initiative.

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

[72] http://samhsa.gov/sites/default/files/mhbg-5-percent-set-aside-guidance.pdf

[73] http://www.nimh.nih.gov/health/topics/schizophrenia/raise/index.shtml?utm_source=rss_readers&utm_medium=rss&utm_campaign=rss_full

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

DBHR is partnering with Early Assessment and Support Alliance (EASA) to create positive outcomes for Transition Age Youth (TAY), between the ages of 15 and 25, experiencing early serious mental illness, including psychotic disorders or serious emotional disturbance (SED). EASA is a systematic effort that originated in Oregon to prevent early trauma and disability caused by schizophrenia-related conditions. Washington is currently partnering with EASA and Central Washington Comprehensive Mental Health (CWCMH) to implement a pilot program (New Journeys) in Yakima County.

CWCMH was an excellent match for the pilot project based on several key components required to develop a strong Early Psychosis Team. These characteristics include a wellness, recovery and resilience orientation; referrals to inpatient hospital care; linkages with community resources; strong psychiatric supervision and clinical leadership and a willingness to work collaboratively to develop a model that would best serve their community, in addition to assisting in developing the frame work for a statewide model.

New Journey's will be integrating methodology from evidence-based "toolkits" developed by the Substance Abuse Mental Health Services Administration. Toolkits include multi-family groups, Individual Resiliency Training (IRT), dual diagnosis treatment (substance use disorder and psychosis).

IRT will be used to help TAY, experiencing a SMI or a SED, identify and enhance their strengths and resiliency factors, increase their illness management skills, and learn skills to increase their success in achieving personal goals, such as employment, education, and positive relationships.

Along with treatment, the New Journey's team will be delivering statewide presentations with practioners, clinicians, and behavioral health specialist to increase awareness of early psychosis, while increasing the level of resources and information available to individuals who engage with and serve transition age youth experiencing SMI or SED. Along with the presentations and trainings, the New Journeys' Pilot Program will be launching two statewide early psychosis initiatives in August 2015:

1. QPR (Question, Persuade, and Refer) for Psychosis: New Journeys is partnering with The QPR Institute to offer an online opportunity for mental health agency staff, school and juvenile justice personnel to be trained as QPR Gatekeeper Instructors. First Episode Psychosis (FEP) is associated with increased risk of suicidal behaviors in TAY. The QPR Institute has modified this training for Washington to include early recognition and response to TAY experiencing a SMI or SED.
2. RecoveryLibrary™: New Journeys is partnering with Pat Deegan and Associates to provide extensive early psychosis online resources and materials for up to 2,500 mental health providers, Juvenile Justice, Mental Health providers, and schools (High School, Community/Technical Colleges, and State Universities and Colleges). There is an immediate need to increase statewide awareness and education, and QPR for Psychosis Gatekeeper Training and the RecoveryLibrary ™ will share this important information and provide tools and resources to the key people who are most likely to engage with transitional age youth who are experiencing SMI or SED.

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

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

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

The research and evaluation project will be collaborative, recovery oriented and client centered. The goal will be to engage TAY with SMI or SED, families of the

TAY, and providers to examine issues that matter to them, such as the duration and quality of life, functional outcomes, and costs of care. Beyond looking at treatment itself, there will be measures of the impact and value of the New Journeys model, as well as the impact of social factors on therapeutic outcomes.

Environmental Factors and Plan

6. Participant Directed Care

Narrative Question:

As states implement policies that support self-determination and improve person-centered service delivery, one option that states may consider is the role that vouchers may play in their overall financing strategy. Many states have implemented voucher and self-directed care programs to help individuals gain increased access to care and to enable individuals to play a more significant role in the development of their prevention, treatment, and recovery services. The major goal of a voucher program is to ensure individuals have a genuine, free, and independent choice among a network of eligible providers. The implementation of a voucher program expands mental and substance use disorder treatment capacity and promotes choice among clinical treatment and recovery support providers, providing individuals with the ability to secure the best treatment options available to meet their specific needs. A voucher program facilitates linking clinical treatment with other authorized services, such as critical recovery support services that are not otherwise reimbursed, including coordination, childcare, motivational development, early/brief intervention, outpatient treatment, medical services, support for room and board while in treatment, employment/education support, peer resources, family/parenting services, or transportation.

Voucher programs employ an indirect payment method with the voucher expended for the services of the individual's choosing or at a provider of their choice. States may use SABG and MHBG funds to introduce or enhance behavioral health voucher and self-directed care programs within the state. The state should assess the geographic, population, and service needs to determine if or where the voucher system will be most effective. In the system of care created through voucher programs, treatment staff, recovery support service providers, and referral organizations work together to integrate services.

States interested in using a voucher system should create or maintain a voucher management system to support vouchering and the reporting of data to enhance accountability by measuring outcomes. Meeting these voucher program challenges by creating and coordinating a wide array of service providers, and leading them though the innovations and inherent system change processes, results in the building of an integrated system that provides holistic care to individuals recovering from mental and substance use disorders. Likewise, every effort should be made to ensure services are reimbursed through other public and private resources, as applicable and in ways consistent with the goals of the voucher program

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Not Required

Environmental Factors and Plan

7. Program Integrity

Narrative Question:

SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds.

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for behavioral health services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 USC §§ 300x–5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 USC § 300x– 55, SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for substance abuse, SAMSHA will release guidance imminently to the states on use of block grant funds for these purposes. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The Affordable Care Act may offer additional health coverage options for persons with behavioral health conditions and block grant expenditures should reflect these coverage options. The MHBG and SABG resources are to be used to support, not supplant, individuals and services that will be covered through the Marketplaces and Medicaid. SAMHSA will provide additional guidance to the states to assist them in complying with program integrity recommendations; develop new and better tools for reviewing the block grant application and reports; and train SAMHSA staff, including Regional Administrators, in these new program integrity approaches and tools. In addition, SAMHSA will work with CMS and states to discuss possible strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance abuse programs, and activities for adults with SMI and children with SED.

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

Please consider the following items as a guide when preparing the description of the state's system:

1. Does the state have a program integrity plan regarding the SABG and MHBG funds?
2. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers?
3. Describe the program integrity activities the state employs for monitoring the appropriate use of block grant funds and oversight practices:
    a. Budget review;
    b. Claims/payment adjudication;
    c. Expenditure report analysis;
    d. Compliance reviews;
    e. Client level encounter/use/performance analysis data; and
    f. Audits.
4. Describe payment methods, used to ensure the disbursement of funds are reasonable and appropriate for the type and quantity of services delivered.
5. Does the state provide assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards?
6. How does the state ensure block grant funds and state dollars are used for the four purposes?

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

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

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

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

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

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

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

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

Environmental Factors and Plan

8. Tribes

Narrative Question:

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the 2009 Memorandum on Tribal Consultation[74] to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

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

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that 67% of American Indian and Alaska Natives live off-reservation. SSAs/SMHAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the state. States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

Please consider the following items as a guide when preparing the description of the state's system:

1. Describe how the state has consulted with tribes in the state and how any concerns were addressed in the block grant plan.
2. Describe current activities between the state, tribes and tribal populations.

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

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[74] http://www.whitehouse.gov/the-press-office/memorandum-tribal-consultation-signed-president

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

The Division of Behavioral Health and Recovery is committed to the establishment of inter-governmental relationships with the tribes of Washington State and to the development and delivery of beneficial services to Indian families and individuals in need. DBHR recognizes the impor¬tance of partnering with tribes and Urban Indian communities across the state to assure that Indian people have access to services that are culturally sensitive and appropriate.

The division has worked to develop a strong relationship with Washington's 29 federally recognized tribes, four non-federally recognized tribes, and seven recognized American Indian organizations to improve the behavioral health of Native American peoples and communities. Meetings held between DBHR staff and tribal governments provide a forum to discuss Government-to-Government (G2G) protocol, policy impacts, contracting issues, and funding opportunities. These meetings also provide an opportunity to share information and discuss current issues.

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 importance and vital need to work in partnership with tribes and Urban Indian communities across the state to ensure that Native American people have equitable access to behavioral health services and that the services are culturally sensitive and appropriate.

Tribal representation is integral to ensuring that DBHR is able to meet the needs within tribal communities. The Department's Office of Indian Policy (OIP) and IPAC assist DBHR in reaching out to tribal members to participate on each advisory council.
Washington State Department of Social and Health Services (DSHS) established a consultation policy, called Administrative Policy 7.01, in collaboration with the Indian Policy Advisory Committee (IPAC). IPAC is an advisory committee, within DSHS, with representatives from the 29 Federally Recognized Tribes and seven Recognized American Indian Organizations (RAIOs) within Washington State. Administrative Policy 7.01 gives the protocol for communication and collaboration with the Federally Recognized Tribes and RAIOs in Washington State, and the protocol for consultation with the Federally Recognized Tribes in Washington State.

While not a formal component of this administration, the Tribal Centric Behavioral Health initiative works across all aspects of BHSIA. The DSHS Office of Indian Policy is one of its primary partners. The initiative's work actively involves representatives from the American Indian Health Com¬mission, the Indian Policy Advisory Committee, and the North West Portland Area Indian Health Board. Additional partners include representatives from the Health Care Authority, the Regional Support Networks, and Indian Health Services.

The group meets monthly, with subgroups related to specific topics meeting the same day on an ad hoc basis. The work group was implemented to help shape and design a new mental health system for American Indians and Alaskan Natives. Over the last three years of meetings the Tribal Cen¬tric Behavioral Health Work Group identified issues, reviewed problems and explored multiple solutions to problems. The work group has addressed not only those issues surfaced at the initial 2009 meeting, but also continues to addressed emerging concerns regarding the provision of behavioral health services and the interface between tribal providers, Tribes, individual American Indians and Alaskan Natives, DSHS, and the RSN system. The Work Group's current focus is on the implementation of SSB 6312, which will integrate publicly funded substance use disorder treatment programs into the public mental health system, transitioning substance use disorder treatment into a managed care environment through new entities called Behavioral Health Organizations (BHOs).

In 2013 the Tribal Centric Behavioral Health Work Group submitted a report to the legislature describing a Tribal Centric Behavioral Health System and identifying the steps necessary to implement the system. The report was required by Section 7 of SSB 5732. In the report the work group identified the defining characteristics that exemplify a Tribal Centric Behavioral Health System. Those characteristics should demonstrate:

• The value and importance of individual choice.
• The value and importance of American Indians/Alaska Natives having access to Tribal and urban Indian programs providing behavioral health services.
• Mandatory changes to RSNs and how they relate with Tribes and American Indians/Alaska Natives.
• Required cultural competency training for RSN and state hospital staff working with the American Indians/Alaska Natives population.
• Coordinated and centralized communications between DSHS and HCA in policy development and designing, and modifying billing and re¬porting procedures.
• Conducting a feasibility study for structuring one or more residential programs. The study should determine what type of facility would best serve American Indians/Alaska Natives population (freestanding evaluation and treatment (E&T), crisis triage, dual diagnosis beds, or a combination of all three).

The Work Group membership voiced that individual choice should be the guiding value of any future system. Work Group members also emphasized that the future system should allow American Indians/Alaska Natives to continue to have direct access to Tribal and urban Indian behavioral health programs. Those American Indians/Alaska Natives who have chosen to receive services through the existing RSN system, or its successor, should be able to continue to receive those services if they so choose. They should be able to do this without disruption and without having to be subjected to an opt-in or opt-out process so that they may continue receiving care. The Work Group stipulated that to adequately and appropriately serve the American Indian/Alaska Natives population, especially those Tribal members living on reservations, the RSNs must make serious and significant changes in the way they interact with Tribes and Tribal members.

There is concern within the tribal behavioral health program that the mental health Medicaid encounter data does not accurately report the number of tribal Medicaid Tribal clients. Not all tribal members in the behavioral health system are on Medicaid creating a void in the data because the reality of the need is not well represented by the Medicaid data. It should be noted that most tribal members do not use the Regional Support Networks (RSNs) services to access mental health services whereby creating an additional void in data.

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

Having complete date is always a challenge. One of the important things to do when presenting information is to accurately describe the study or reporting population and to be cautious interpreting results. DBHR plans to work with tribes, through the Tribal Centric Workgroups, on building strategies to obtain more complete data.

Environmental Factors and Plan

9. Primary Prevention for Substance Abuse

Narrative Question:

Federal law requires that states spend no less than 20 percent of their SABG allotment on primary prevention programs, although many states spend more. Primary prevention programs, practices, and strategies are directed at individuals who have not been determined to require treatment for substance abuse.

Federal regulation (45 CFR 96.125) requires states to use the primary prevention set-aside of the SABG to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance abuse. The program must include, but is not limited to, the following strategies:

- Information Dissemination provides knowledge and increases awareness of the nature and extent of alcohol and other drug use, abuse, and addiction, as well as their effects on individuals, families, and communities. It also provides knowledge and increases awareness of available prevention and treatment programs and services. It is characterized by one-way communication from the information source to the audience, with limited contact between the two.
- Education builds skills through structured learning processes. Critical life and social skills include decision making, peer resistance, coping with stress, problem solving, interpersonal communication, and systematic and judgmental capabilities. There is more interaction between facilitators and participants than there is for information dissemination.
- Alternatives provide opportunities for target populations to participate in activities that exclude alcohol and other drugs. The purpose is to discourage use of alcohol and other drugs by providing alternative, healthy activities.
- Problem Identification and Referral aims to identify individuals who have indulged in illegal or age-inappropriate use of tobacco, alcohol or other substances legal for adults, and individuals who have indulged in the first use of illicit drugs. The goal is to assess if their behavior can be reversed through education. This strategy does not include any activity designed to determine if a person is in need of treatment.
- Community-based Process provides ongoing networking activities and technical assistance to community groups or agencies. It encompasses neighborhood-based, grassroots empowerment models using action planning and collaborative systems planning
- Environmental Strategies establish or changes written and unwritten community standards, codes, and attitudes. The intent is to influence the general population's use of alcohol and other drugs.

States should use a variety of strategies that target populations with different levels of risk. Specifically, prevention strategies can be classified using the IOM Model of Universal, Selective, and Indicated, which classifies preventive interventions by targeted population. The definitions for these population classifications are:

- Universal: The general public or a whole population group that has not been identified based on individual risk.
- Selective: Individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average.
- Indicated: Individuals in high-risk environments that have minimal but detectable signs or symptoms foreshadowing disorder or have biological markers indicating predispositions for disorder but do not yet meet diagnostic levels.

It is important to note that classifications of preventive interventions by strategy and by IOM category are not mutually exclusive, as strategy classification indicates the type of activity while IOM classification indicates the populations served by the activity. Federal regulation requires states to use prevention set-aside funding to implement substance abuse prevention interventions in all six strategies. SAMHSA also recommends that prevention set-aside funding be used to target populations with all levels of risk: universal, indicated, and selective populations.

While the primary prevention set-aside of the SABG must be used only for primary substance abuse prevention activities, it is important to note that many evidence-based substance abuse prevention programs have a positive impact not only on the prevention of substance use and abuse, but also on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. This reflects the fact that substance use and other aspects of behavioral health share many of the same risk and protective factors.

The backbone of an effective prevention system is an infrastructure with the ability to collect and analyze epidemiological data on substance use and its associated consequences and use this data to identify areas of greatest need. Good data also enable states to identify, implement, and evaluate evidence-based programs, practices, and policies that have the ability to reduce substance use and improve health and well-being in communities. In particular, SAMHSA strongly encourages states to use data collected and analyzed by their SEOWs to help make data- driven funding decisions. Consistent with states using data to guide their funding decisions, SAMHSA encourages states to look closely at the data on opioid/prescription drug abuse, as well as underage use of legal substances, such as alcohol, and marijuana in those states where its use has been legalized. SAMHSA also encourages states to use data-driven approaches to allocate funding to communities with fewer resources and the greatest behavioral health needs.

SAMHSA expects that state substance abuse agencies have the ability to implement the five steps of the strategic prevention framework (SPF) or an equivalent planning model that encompasses these steps:

1. Assess prevention needs;
2. Build capacity to address prevention needs;
3. Plan to implement evidence-based strategies that address the risk and protective factors associated with the identified needs;
4. Implement appropriate strategies across the spheres of influence (individual, family, school, community, environment) that reduce substance abuse and its associated consequences; and
5. Evaluate progress towards goals.

States also need to be prepared to report on the outcomes of their efforts on substance abuse- related attitudes and behaviors. This means that state-funded prevention providers will need to be able to collect data and report this information to the state. With limited resources, states should also look for opportunities to leverage different streams of funding to create a coordinated data driven substance abuse prevention system. SAMHSA expects that states coordinate the use of all substance abuse prevention funding in the state, including the primary prevention set-aside of the SABG, discretionary SAMHSA grants such as the Partnerships for Success (PFS) grant, and other federal, state, and local prevention dollars, toward common outcomes to strive to create an impact in their state's use, misuse or addiction metrics.

Please consider the following items as a guide when preparing the description of the state's system:

1. Please indicate if the state has an active SEOW. If so, please describe:
    - The types of data collected by the SEOW (i.e. incidence of substance use, consequences of substance use, and intervening variables, including risk and protective factors);
    - The populations for which data is collected (i.e., children, youth, young adults, adults, older adults, minorities, rural communities); and
    - The data sources used (i.e. archival indicators, NSDUH, Behavioral Risk Factor Surveillance System, Youth Risk Behavior Surveillance System, Monitoring the Future, Communities that Care, state-developed survey).
2. Please describe how needs assessment data is used to make decisions about the allocation of SABG primary prevention funds.
3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?
4. Please describe if the state has:
    a. A statewide licensing or certification program for the substance abuse prevention workforce;
    b. A formal mechanism to provide training and technical assistance to the substance abuse prevention workforce; and
    c. A formal mechanism to assess community readiness to implement prevention strategies.
5. How does the state use data on substance use consumption patterns, consequences of use, and risk and protective factors to identify the types of primary prevention services that are needed (e.g., education programs to address low perceived risk of harm from marijuana use, technical assistance to communities to maximize and increase enforcement of alcohol access laws to address easy access to alcohol through retail sources)?
6. Does the state have a strategic plan that addresses substance abuse prevention that was developed within the last five years? If so, please describe this plan and indicate whether it is used to guide decisions about the use of the primary prevention set-aside of the SABG.
7. Please indicate if the state has an active evidence-based workgroup that makes decisions about appropriate strategies in using SABG primary prevention funds and describe how the SABG funded prevention activities are coordinated with other state, local or federally funded prevention activities to create a single, statewide coordinated substance abuse prevention strategy.
8. Please list the specific primary prevention programs, practices and strategies the state intends to fund with SABG primary prevention dollars in each of the six prevention strategies. Please also describe why these specific programs, practices and strategies were selected.
9. What methods were used to ensure that SABG dollars are used to fund primary substance abuse prevention services not funded through other means?
10. What process data (i.e. numbers served, participant satisfaction, attendance) does the state intend to collect on its funded prevention strategies and how will these data be used to evaluate the state's prevention system?
11. What outcome data (i.e., 30-day use, heavy use, binge use, perception of harm, disapproval of use, consequences of use) does the state intend to collect on its funded prevention strategies and how will this data be used to evaluate the state's prevention system?

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

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

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

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

Table 1 SEOW Data Sources

Data Source	Types of Data On Substance Use	Target Populations
WA Healthy Youth Survey • State-developed school-based student survey • Biennial since 2002	Consumption: • Alcohol, tobacco, marijuana, prescription drug, other illicit drugs: current use, lifetime use, age at first use, level of use, use at school. Consequence: • Depressive feelings, anxiety, suicide and suicide attempts; • Youth delinquency; • Motor vehicle safety; • School attendance, academic performance. Intermediate: • Risk and protective factors.	• WA 6th, 8th, 10th, and 12th graders in all public schools; • In small school districts, 7th, 9th, 11th graders are also eligible to participate in 2014; • All race/ethnicity groups; • Rural and urban communities.
BRFSS • Core questionnaire • State-added questions	Consumption: • Alcohol: alcohol consumption module, use of liquor • Marijuana: current, lifetime use; mode of use, medical marijuana use • Prescription drugs: use of pain killers Consequence: • Drinking and driving; driving under the influence of marijuana	• Adults 18 and above; • All race/ethnicity groups.
NSDUH state estimates	Consumption: • Alcohol, tobacco, marijuana, prescription pain relievers, illicit drugs Consequence: • Dependence or abuse Intermediate: • Perception of risk in binge drinking, smoking marijuana and cigarettes	• Youth, young adults, and adults
WA Young Adult Health Survey • State-developed internet-based survey • Annually 2014, 2015	Consumption: • Extensive set of questions on marijuana use rates and use patterns • Rates and use patterns of alcohol, tobacco, heroin and pain relievers Consequence: • Physical and mental problems caused by marijuana and alcohol use	

• Driving under the influence of marijuana
Intermediate:
• Perception of access, risk, and norms about the use of marijuana, alcohol, heroin, and pain relievers • Young adults 18-25
• All race/ethnicity groups
• Urban and rural areas
The Community Outcomes and Risk Evaluation (CORE) System
• Archival indicator database and reports
• Updated twice a year Consequence:
• Alcohol and drug related deaths
• Criminal justice involvement
• School attendance and academic outcomes
• Alcohol-related traffic fatalities
• Clients of alcohol and drug treatment services
Intermediate
• An extensive set of variables in community, school, family, and individual domains • Youth, adults, family, community, schools
• Reported at the state, county, locale, and school district levels

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

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

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

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

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

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

The Data Books include measures for the Consequences, Consumption, and Intervening

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

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

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

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

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

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

Allocation Formulas
Native American Tribes are offered a set allocation based on a long-standing tribal enrollment calculation. The Indian Nation or Tribal Government determines how much of the overall allocation is used for substance abuse treatment services and how much is used for substance abuse prevention services. These figures are taken into account to maintain the set-aside percentages for prevention services.
Community Prevention and Wellness Initiative (CPWI) communities were determined using a ranked risk profile of each school district in each county consisting of 26

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

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

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

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

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

DBHR has two major conference trainings. One, an annual Prevention Summit that provide cutting-edge information on prevention research and practices as well as a forum for providers to develop new skills for implementing prevention services. The other is a Coalition Leadership Institute that is designed to enhance community coalition development and maintenance skills.

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

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

We have a standing Memorandum of Agreement with the SSA in Oregon State to maintain the evidence-based program and practices list that is posted on the Athena forum website. http://www.theathenaforum.org/learning_library/ebp. Sub-recipients for

primary prevention services select from this list. The contract requires a minimum of 60% of prevention programs be evidence-based.
The following table of evidence-based, primary prevention programs, practices and strategies will be implemented at the local level through the Community Coalitions and Tribal Nations. Each CPWI sub-recipient develops a local Strategic Plan Tribes develop work plans that address local tribal needs and are reviewed and approved by the state prior to implementation. There are additional innovative programs that are supported with SABG funds at the local level; all of which must follow the CSAP Principles of Effectiveness. The Strategic Action Plans are developed using the Strategic Prevention Framework steps. Following a community needs and resource assessment, gaps analysis and prioritization process, the communities identify their local conditions and strategies.

EBP Curriculum	CSAP Strategy
All Stars	Prevention Education
CAST (Coping And Support Training)	Prevention Education
Class Action	Prevention Education
Community Trials Intervention To Reduce High-Risk Drinking	Environmental
Curriculum-Based Support Group (CBSG) Program	Prevention Education
Family Matters	Prevention Education
Good Behavior Game (GBG)	Prevention Education
Guiding Good Choices	Prevention Education
Healthy Alternatives for Little Ones (HALO)	Prevention Education
Incredible Years	Prevention Education
Keep A Clear Mind (KACM)	Prevention Education
LifeSkills Training (LST)	Prevention Education
Media Ready	Environmental
Mentoring: Big Brothers/Big Sisters	Alternative Activities
Nurturing Parenting Programs	Prevention Education
PAL Peer Assistance and Leadership	Alternative Activities
Parenting Wisely	Prevention Education
Positive Action	Environmental
Project ALERT	Prevention Education
Project Northland	Prevention Education
Project SUCCESS	Prevention Education
Protecting You/Protecting Me	Prevention Education
Reward & Reminder	Environmental
Say It Straight	Prevention Education
Second Step	Prevention Education
SPORT	Prevention Education
Strengthening Families Program	Prevention Education
Strengthening Families Program: For Parents and Youth 10-14	Prevention Education
Strengthening Multi-Ethnic Families and Communities	Prevention Education

Environmental Factors and Plan

10. Quality Improvement Plan

Narrative Question:

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

In an attachment to this application, states should submit a CQI plan for FY 2016-FY 2017.

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Not Required

Environmental Factors and Plan

11. Trauma

Narrative Question:

Trauma [75] is a widespread, harmful and costly public health problem. It occurs as a result of violence, abuse, neglect, loss, disaster, war and other emotionally harmful experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed, that is, based on the knowledge and understanding of trauma and its far-reaching implications.

The effects of traumatic events place a heavy burden on individuals, families and communities and create challenges for public institutions and service systems [76]. Although many people who experience a traumatic event will go on with their lives without lasting negative effects, others will have more difficulty and experience traumatic stress reactions. Emerging research has documented the relationships among exposure to traumatic events, impaired neurodevelopmental and immune systems responses, and subsequent health risk behaviors resulting in chronic physical or behavioral health disorders. Research has also indicated that with appropriate supports and intervention, people can overcome traumatic experiences. However, most people go without these services and supports.

Individuals with experiences of trauma are found in multiple service sectors, not just in behavioral health. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated behavioral health problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often themselves re-traumatizing, making it necessary to rethink doing “business as usual.” These public institutions and service settings are increasingly adopting a trauma-informed approach guided by key principles of safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues, and incorporation of trauma-specific screening, assessment, treatment, and recovery practices.

To meet the needs of those they serve, states should take an active approach to addressing trauma. Trauma screening matched with trauma-specific therapies, such as exposure therapy or trauma-focused cognitive behavioral approaches, should be used to ensure that treatments meet the needs of those being served. States should also consider adopting a trauma-informed approach consistent with “SAMHSA’s Concept of Trauma and Guidance for a Trauma-Informed Approach”. [77] This means providing care based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be supportive and avoid traumatizing the individuals again. It is suggested that the states uses SAMHSA’s guidance for implementing the trauma-informed approach discussed in the Concept of Trauma [78] paper.

Please consider the following items as a guide when preparing the description of the state’s system:

1. Does the state have policies directing providers to screen clients for a personal history of trauma and to connect individuals to trauma-focused therapy?
2. Describe the state’s policies that promote the provision of trauma-informed care.
3. How does the state promote the use of evidence-based trauma-specific interventions across the lifespan?
4. Does the state provide trainings to increase capacity of providers to deliver trauma-specific interventions?

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

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75 Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*

76 http://www.samhsa.gov/trauma-violence/types

77 http://store.samhsa.gov/product/SMA14-4884

78 *Ibid*

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Not Required

Environmental Factors and Plan

12. Criminal and Juvenile Justice

Narrative Question:

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one third meet criteria for having co-occurring substance abuse and mental health problems. Successful diversion from or re-entering the community from detention, jails, and prisons is often dependent on engaging in appropriate substance use and/or mental health treatment. Some states have implemented such efforts as mental health, veteran and drug courts, crisis intervention training and re-entry programs to help reduce arrests, imprisonment and recidivism.[79]

The SABG and MHBG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment. Communities across the United States have instituted problem-solving courts, including those for defendants with mental and substance use disorders. These courts seek to prevent incarceration and facilitate community-based treatment for offenders, while at the same time protecting public safety. There are two types of problem-solving courts related to behavioral health: drug courts and mental health courts. In addition to these behavioral health problem-solving courts, some jurisdictions operate courts specifically for DWI/DUI, veterans, families, and reentry, as well as courts for gambling, domestic violence, truancy, and other subject-specific areas.[80] [81] Rottman described the therapeutic value of problem-solving courts: "Specialized courts provide a forum in which the adversarial process can be relaxed and problem-solving and treatment processes emphasized. Specialized courts can be structured to retain jurisdiction over defendants, promoting the continuity of supervision and accountability of defendants for their behavior in treatment programs." Youths in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.[82]

Expansions in insurance coverage will mean that many individuals in jails and prisons, who generally have not had health coverage in the past, will now be able to access behavioral health services. Addressing the behavioral health needs of these individuals can reduce recidivism, improve public safety, reduce criminal justice expenditures, and improve coordination of care for a population that disproportionately experiences costly chronic physical and behavioral health conditions. Addressing these needs can also reduce health care system utilization and improve broader health outcomes. Achieving these goals will require new efforts in enrollment, workforce development, screening for risks and needs, and implementing appropriate treatment and recovery services. This will also involve coordination across Medicaid, criminal and juvenile justice systems, SMHAs, and SSAs.

A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with mental and/or substance use disorders from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment; loss of eligibility resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

Please consider the following items as a guide when preparing the description of the state's system:

1. Are individuals involved in, or at risk of involvement in, the criminal and juvenile justice system enrolled in Medicaid as a part of coverage expansions?
2. Are screening and services provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?
3. Do the SMHA and SSA coordinate with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral health services provided in correctional facilities and the reentry process for those individuals?
4. Are cross-trainings provided for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?

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

[79] http://csgjusticecenter.org/mental-health/

[80] The American Prospect: In the history of American mental hospitals and prisons, *The Rehabilitation of the Asylum*. David Rottman,2000.

[81] A report prepared by the Council of State Governments. Justice Center. Criminal Justice/Mental Health Consensus Project. New York, New York for the Bureau of Justice Assistance Office of Justice Programs, U.S. Department of Justice, Renee L. Bender, 2001.

[82] Journal of Research in Crime and Delinquency: *Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice.* Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Renée L. Binder. OJJDP Model Programs Guide

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Not Required

Environmental Factors and Plan

13. State Parity Efforts

Narrative Question:

MHPAEA generally requires group health plans and health insurance issuers to ensure that financial requirements and treatment limitations applied to M/SUD benefits are no more restrictive than the requirements or limitations applied to medical/surgical benefits. The legislation applies to both private and public sector employer plans that have more than 50 employees, including both self-insured and fully insured arrangements. MHPAEA also applies to health insurance issuers that sell coverage to employers with more than 50 employees. The Affordable Care Act extends these requirements to issuers selling individual market coverage. Small group and individual issuers participating in the Marketplaces (as well as most small group and individual issuers outside the Marketplaces) are required to offer EHBs, which are required by statute to include services for M/SUDs and behavioral health treatment - and to comply with MHPAEA. Guidance was released for states in January 2013.[83]

MHPAEA requirements also apply to Medicaid managed care, alternative benefit plans, and CHIP. ASPE estimates that more than 60 million Americans will benefit from new or expanded mental health and substance abuse coverage under parity requirements. However, public awareness about MHPAEA has been limited. Recent research suggests that the public does not fully understand how behavioral health benefits function, what treatments and services are covered, and how MHPAEA affects their coverage.[84]

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

SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues.

Please consider the following items as a guide when preparing the description of the state's system:

1. What fiscal resources are used to develop communication plans to educate and raise awareness about parity?
2. Does the state coordinate across public and private sector entities to increase consumer awareness and understanding about benefits of the law (e.g., impacts on covered benefits, cost sharing, etc.)?
3. Does the state coordinate across public and private sector entities to increase awareness and understanding among health plans and health insurance issuers of the requirements of MHPAEA and related state parity laws and to provide technical assistance as needed?

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

[83] http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf

[84] Rosenbach, M., Lake, T., Williams, S., Buck, S. (2009). Implementation of Mental Health Parity: Lessons from California. Psychiatric Services. 60(12) 1589-1594

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Not Required

Environmental Factors and Plan

14. Medication Assisted Treatment

Narrative Question:

There is a voluminous literature on the efficacy of FDA-approved medications for the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for medication-assisted treatment of these disorders is described in SAMHSA TIPs 40[85], 43[86], 45[87], and 49[88]. SAMHSA strongly encourages the states to require that treatment facilities providing clinical care to those with substance use disorders be required to either have the capacity and staff expertise to use MAT or have collaborative relationships with other providers such that these MATs can be accessed as clinically indicated for patient need. Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs.

SAMHSA strongly encourages states to require the use of FDA-approved MATs for substance use disorders where clinically indicated (opioid use disorders with evidence of physical dependence, alcohol use disorders, tobacco use disorders) and particularly in cases of relapse with these disorders. SAMHSA is asking for input from states to inform SAMHSA's activities.

Please consider the following items as a guide when preparing the description of the state's system:

1. How will or can states use their dollars to develop communication plans to educate and raise awareness within substance abuse treatment programs and the public regarding medication-assisted treatment for substance use disorders?
2. What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that need access to medication-assisted treatment for substance use disorders, particularly pregnant women?
3. What steps will the state take to assure that evidence-based treatments related to the use of FDA-approved medications for treatment of substance use disorders are used appropriately (appropriate use of medication for the treatment of a substance use disorder, combining psychosocial treatments with medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, advocacy with state payers)?

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

[85] http://store.samhsa.gov/product/TIP-40-Clinical-Guidelines-for-the-Use-of-Buprenorphine-in-the-Treatment-of-Opioid-Addiction/SMA07-3939

[86] http://store.samhsa.gov/product/TIP-43-Medication-Assisted-Treatment-for-Opioid-Addiction-in-Opioid-Treatment-Programs/SMA12-4214

[87] http://store.samhsa.gov/product/TIP-45-Detoxification-and-Substance-Abuse-Treatment/SMA13-4131

[88] http://store.samhsa.gov/product/TIP-49-Incorporating-Alcohol-Pharmacotherapies-Into-Medical-Practice/SMA13-4380

Please use the box below to indicate areas of technical assistance needed related to this section:

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Environmental Factors and Plan

15. Crisis Services

Narrative Question:

In the on-going development of efforts to build an evidence-based robust system of care for persons diagnosed with SMI, SED and addictive disorders and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from behavioral health crises.

SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with behavioral health conditions and their families.

According to SAMHSA's publication, Practice Guidelines: Core Elements for Responding to Mental Health Crises[89] ,

> "Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with behavioral health issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs and better invest resources. The array of services and supports being used to address crisis response include the following:

Crisis Prevention and Early Intervention:

- Wellness Recovery Action Plan (WRAP) Crisis Planning
- Psychiatric Advance Directives
- Family Engagement
- Safety Planning
- Peer-Operated Warm Lines
- Peer-Run Crisis Respite Programs
- Suicide Prevention

Crisis Intervention/Stabilization:

- Assessment/Triage (Living Room Model)
- Open Dialogue
- Crisis Residential/Respite
- Crisis Intervention Team/ Law Enforcement
- Mobile Crisis Outreach
- Collaboration with Hospital Emergency Departments and Urgent Care Systems

Post Crisis Intervention/Support:

- WRAP Post-Crisis
- Peer Support/Peer Bridgers
- Follow-Up Outreach and Support
- Family-to-Family engagement
- Connection to care coordination and follow-up clinical care for individuals in crisis
- Follow-up crisis engagement with families and involved community members

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

[89]Practice Guidelines: Core Elements for Responding to Mental Health Crises. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Not Required

Environmental Factors and Plan

16. Recovery

Narrative Question:

The implementation of recovery-based approaches is imperative for providing comprehensive, quality behavioral health care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals.

Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of health (access to quality health and behavioral health treatment), home (housing with needed supports), purpose (education, employment, and other pursuits), and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. This includes the use of psychotropic or other medications for mental illnesses or addictions to assist in the diminishing or elimination of symptoms as needed. Further, the use of psychiatric advance directives is encouraged to provide an individual the opportunity to have an active role in their own treatment even in times when the severity of their symptoms may impair cognition significantly. Resolution of symptoms through acute care treatment contributes to the stability necessary for individuals to pursue their ongoing recovery and to make use of SAMHSA encouraged recovery resources.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders.

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Examples of evidence-based and emerging practices in peer recovery support services include, but are not limited to, the following:

- Drop-in centers
- Peer-delivered motivational interviewing
- Peer specialist/Promotoras
- Clubhouses
- Self-directed care
- Supportive housing models
- Recovery community centers
- WRAP
- Evidenced-based supported
- Family navigators/parent support partners/providers
- Peer health navigators
- Peer wellness coaching
- Recovery coaching
- Shared decision making
- Telephone recovery checkups
- Warm lines
- Whole Health Action Management (WHAM)
- Mutual aid groups for individuals with MH/SA Disorders or CODs
- Peer-run respite services
- Person-centered planning
- Self-care and wellness approaches
- Peer-run crisis diversion services
- Wellness-based community campaign

employment

SAMHSA encourages states to take proactive steps to implement recovery support services, and is seeking input from states to address this position. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Recovery is based on the involvement of consumers/peers and their family members. States should work to support and help strengthen existing consumer, family, and youth networks; recovery organizations; and community peer support and advocacy organizations in expanding self-advocacy, self-help programs, support networks, and recovery support services. There are many activities that SMHAs and SSAs can undertake to engage these individuals and families. In the space below, states should describe their efforts to engage individuals and families in developing, implementing and monitoring the state mental health and substance abuse treatment system.

Please consider the following items as a guideline when preparing the description of the state's system:

1. Does the state have a plan that includes: the definition of recovery and recovery values, evidence of hiring people in recovery leadership roles, strategies to use person-centered planning and self-direction and participant-directed care, variety of recovery services and supports (i.e., peer support, recovery support coaching, center services, supports for self-directed care, peer navigators, consumer/family education, etc.)?
2. How are treatment and recovery support services coordinated for any individual served by block grant funds?
3. Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?
4. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services? Does the state have an accreditation program, certification program, or standards for peer-run services?
5. Does the state conduct empirical research on recovery supports/services identification and dissemination of best practices in recovery supports/services or other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system?
6. Describe how individuals in recovery and family members are involved in the planning, delivery, and evaluation of behavioral health services (e.g., meetings to address concerns of individuals and families, opportunities for individuals and families to be proactive in treatment and recovery planning).
7. Does the state support, strengthen, and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?
8. Provide an update of how you are tracking or measuring the impact of your consumer outreach activities.
9. Describe efforts to promote the wellness of individuals served including tobacco cessation, obesity, and other co-morbid health conditions.
10. Does the state have a plan, or is it developing a plan, to address the housing needs of persons served so that they are not served in settings more restrictive than necessary and are incorporated into a supportive community?
11. Describe how the state is supporting the employment and educational needs of individuals served.

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Not Required

Environmental Factors and Plan

17. Community Living and the Implementation of Olmstead

Narrative Question:

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (1999), provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of substance abuse and mental illness on America's communities. Being an active member of a community is an important part of recovery for persons with behavioral health conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated arrangement appropriate and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with behavioral health needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to Section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office of Civil Rights (OCR) cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other residences that have institutional characteristics to house persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

1. Describe the state's Olmstead plan including housing services provided, home and community based services provided through Medicaid, peer support services, and employment services.
2. How are individuals transitioned from hospital to community settings?
3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?
4. Describe any litigation or settlement agreement with DOJ regarding community integration for children with SED or adults with SMI in which the state is involved?

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Not Required

Environmental Factors and Plan

18. Children and Adolescents Behavioral Health Services

Narrative Question:

MHBG funds are intended to support programs and activities for children with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious mental disorder that contributes to substantial impairment in their functioning at home, at school, or in the community.[90] Most mental health disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.[91] For youth between the ages of 10 and 24, suicide is the third leading cause of death.[92]

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.[93] Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with more than 160 grants awarded to states and communities, and every state has received at least one CMHI grant. In 2011, SAMHSA awarded System of Care Expansion grants to 24 states to bring this approach to scale in states. In terms of adolescent substance abuse, in 2007, SAMHSA awarded State Substance Abuse Coordinator grants to 16 states to begin to build a state infrastructure for substance abuse treatment and recovery-oriented systems of care for youth with substance use disorders. This work has continued with a focus on financing and workforce development to support a recovery-oriented system of care that incorporates established evidence-based treatment for youth with substance use disorders.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or substance use disorders and co-occurring disorders and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child's, youth's and young adult's functioning in their home, school, and community. The system of care approach provides individualized services, is family driven and youth guided, and builds on the strengths of the child, youth or young adult and their family and promotes recovery and resilience. Services are delivered in the least restrictive environment possible, and using evidence-based practices while providing effective cross-system collaboration, including integrated management of service delivery and costs.[94]

According to data from the National Evaluation of the Children's Mental Health Initiative (2011), systems of care[95]:

- reach many children and youth typically underserved by the mental health system;
- improve emotional and behavioral outcomes for children and youth;
- enhance family outcomes, such as decreased caregiver stress;
- decrease suicidal ideation and gestures;
- expand the availability of effective supports and services; and
- save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious behavioral health needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes non-residential services, like wraparound service planning, intensive care management, outpatient therapy, intensive home-based services, substance abuse intensive outpatient services, continuing care, and mobile crisis response; supportive services, like peer youth support, family peer support, respite services, mental health consultation, and supported education and employment; and residential services, like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification.

Please consider the following items as a guide when preparing the description of the state's system:

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with serious mental and substance use disorders?
2. What guidelines have and/or will the state establish for individualized care planning for children/youth with serious mental, substance

use, and co-occurring disorders?

3. How has the state established collaboration with other child- and youth-serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)?
4. How will the state provide training in evidence-based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?
5. How will the state monitor and track service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders?
6. Has the state identified a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse treatment and recovery support services? If so, what is that position (with contact information) and has it been communicated to the state's lead agency of education?
7. What age is considered to be the cut-off in the state for receiving behavioral health services in the child/adolescent system? Describe the process for transitioning children/adolescents receiving services to the adult behavioral health system, including transition plans in place for youth in foster care.

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

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[90] Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children - United States, 2005-2011. MMWR 62(2).

[91] Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

[92] Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

[93] The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

[94] Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from http://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings/PEP12-CMHI2010.

[95] Department of Health and Human Services. (2013). Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions: Joint CMS and SAMHSA Informational Bulletin. Available from http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-05-07-2013.pdf.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

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

The state has established many protocols to ensure individualized care planning for children and youth with serious mental, substance use, and co-occurring disorders, including:
• Legislative direction for the creation of Behavioral Health Organizations, starting with the integration of Mental Health and Substance Use Disorder in April 2016.
• Implementation of Wraparound with Intensive Services (WISe) emphasizes wraparound approach to both high level and other level need youth cases, adopting the Child and Adolescent Needs and Strengths (CANS) assessment tool to evaluate needs and strengths in multiple domains. Access to Care Standards highlights the need to evaluate functional need problems in all domains.
• As a part of our Washington Administrative Code (WAC) 388-877-0620 Clinical – Individual Service Plan outlines components required for substance use disorder treatment; including, but not limited to:
- Address age, gender, cultural, strengths and/or disability issues identified by the individual or, if applicable, the individual's parent(s) or legal representative.
- Be in a terminology that is understandable to the individual and the individual's family.
- Demonstrate the individual's participation in the development of the plan.
- Document participation of family or significant others, if participation is requested by the individual and is clinically appropriate.
- Be strength-based.
- Contain measurable goals or objectives, or both.

The Family Youth System Partner Roundtable (FYSPRT) provides leadership to influence the establishment and sustainability of Children's Behavioral Health System of Care (SOC) values and principles statewide. One of their primary responsibilities is statewide governance oversight of the SOC and the Recovery-Oriented Systems of Care (ROSCs) being developed in conjunction with State Adolescent Treatment Enhancement and Dissemination (SAT-ED). In collaboration with the SOC and SAT-ED Teams, the FYSPRT recommends strategies to provide behavioral health services and supports for children and youth as well as to monitor and review both process and outcome indicators. The FYSPRT supports and tracks the six goals of the Washington State SOC:
1. Infuse SOC values in all child-serving systems.
2. Expand and sustain effective leadership roles for families, youth, and system partners.
3. Establish an appropriate array of services and resources statewide, including home-and community-based services.
4. Develop and strengthen a workforce that will operationalize SOC values.
5. Build a strong data management system to inform decision-making and track outcomes.
6. Develop sustainable financing and align funding to ensure services are seamless for children, youth, and families.

The state has established collaborations with other child- and youth-serving agencies in the state to address behavioral health needs as evidenced by the coordinated contracts with Children's Long Term Inpatient Program (CLIP) and the work of the CLIP Improvement Team and is strengthened by Systems of Care and TR Statewide, FYSPRT, and Executive Leadership Team (ELT) structures. The Statewide FYSPRT has participation from six youth serving state partners; Rehabilitation Administration (RA), Department of Health (DOH), Children's Administration (CA), Health Care Authority (HCA), Office of Superintendent of Public Instruction (OSPI), Developmental Disabilities Administration (DDA) and a tribal representative who works for RA.

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

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

Monitoring and tracking service utilization, costs, and outcomes for children and youth with mental, substance use, and co-occurring disorders are performed through many different methods. These include:
- Tracking EBP reporting, and multiple input methods for WISe system rollout, and CANs progress tracking
- Through our payment system (ProviderOne)
- Performance based contracting and contract monitoring
- Children’s Behavioral Health Measures
- Through reports from TARGET the data system for SUD services; as well as outcome reports available through SCOPE

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

Treatment
In two counties (one rural, one urban) a pilot project was developed to address co-occurring disorders for students in a school-based setting. This project has been communicated to OPSI and will focus on building capacity for the screening, assessment, referral, case management and treatment to students with co-occurring disorders. This project will enlist a Mental Health Professional, under the direct clinical supervision of a dually licensed Chemical Dependency and Mental Health Professional, to serve a minimum of 50 youth with co-occurring needs. The direct services will be best practices identified by the University of Washington Evidence Based Practice Institute. An integral component of this project is training school staff in Mental Health First Aid. This evidence-based program teaches individuals how to identify and respond to mental health and substance use risk factors and warning signs.

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

Student Assistance Specialists are assigned to designated school sites to provide direct services to students who are at risk and/or harmfully involved with alcohol, tobacco, and other drugs. SAPISP services include:
- Administer a uniform screening instrument to determine levels of substance abuse and mental health concerns.
- Individual and family counseling and interventions on student substance use.
- Peer support groups to address student and/or family substance abuse issues.
- Coordinate and make referrals to treatment and other social service providers.
- School-wide prevention activities that promote healthy messages and decrease substance use.

Environmental Factors and Plan

19. Pregnant Women and Women with Dependent Children

Narrative Question:

Substance-abusing pregnant women have always been the number one priority population in the SAMHSA block grant (Title XIX, Part B, Subpart II, Sec.1922 (c)). A formula based on the FY 1993 and FY 1994 block grants was established to increase the availability of treatment services designed for pregnant women and women with dependent children. The purpose of establishing a "set-aside" was to ensure the availability of comprehensive, substance use disorder treatment, and prevention and recovery support services for pregnant and postpartum women and their dependent children. This population continues to be a priority, given the importance of prenatal care and substance abuse treatment for pregnant, substance using women, and the importance of early development in children. For families involved in the child welfare system, successful participation in treatment for substance use disorders is the best predictor for children remaining with their mothers. Women with dependent children are also named as a priority for specialized treatment (as opposed to treatment as usual) in the SABG regulations. MOE provisions require that the state expend no less than an amount equal to that spent by the state in a base fiscal year for treatment services designed for pregnant women and women with dependent children.

For guidance on components of quality substance abuse treatment services for women, States and Territories can refer to the following documents, which can be accessed through the SAMHSA website at http://www.samhsa.gov/women-children-families: *Treatment Improvement Protocol (TIP) 51, Substance Abuse Treatment; Addressing the Specific Needs of Women; Guidance to States; Treatment Standards for Women with Substance Use Disorders; Family-Centered Treatment for Women with Substance Abuse Disorders: History, Key Elements and Challenges.*

Please consider the following items as a guide when preparing the description of the state's system:

1. The implementing regulation requires the availability of treatment and admission preference for pregnant women be made known and that pregnant women are prioritized for admission to treatment. Please discuss the strategies your state uses to accomplish this.
2. Discuss how the state currently ensures that pregnant women are admitted to treatment within 48 hours.
3. Discuss how the state currently ensures that interim services are provided to pregnant women in the event that a treatment facility has insufficient capacity to provide treatment services.
4. Discuss who within your state is responsible for monitoring the requirements in 1-3.
5. How many programs serve pregnant women and their infants? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP.)
    a. How many of the programs offer medication assisted treatment for the pregnant women in their care?
    b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where pregnant women can receive MAT? If so, where are they?
6. How many programs serve women and their dependent children? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP)
    a. How many of the programs offer medication assisted treatment for the pregnant women in their care?
    b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where women can receive MAT? If so, where are they?

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

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

Agencies work to get pregnant women into services within 24 hours, if a residential placement is needed and not available interim services are provided. If residential services are not needed they are enrolled in outpatient treatment. When services are not available, the provider is required to ensure the following:

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

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

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

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

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

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

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

Environmental Factors and Plan

20. Suicide Prevention

Narrative Question:

In the FY 2016/2017 block grant application, SAMHSA asks states to:

1. Provide the most recent copy of your state's suicide prevention plan; describe when your state will create or update your plan, and how that update will incorporate recommendations from the revised National Strategy for Suicide Prevention (2012).
2. Describe how the state's plan specifically addresses populations for which the block grant dollars are required to be used.
3. Include a new plan (as an attachment to the block grant Application) that delineates the progress of the state suicide plan since the FY 2014-2015 Plan. Please follow the format outlined in the new SAMHSA document Guidance for State Suicide Prevention Leadership and Plans.[96]

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

[96] http://www.samhsa.gov/sites/default/files/samhsa_state_suicide_prevention_plans_guide_final_508_compliant.pdf

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Not Required

Environmental Factors and Plan

21. Support of State Partners

Narrative Question:

The success of a state's MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with mental and substance use disorders who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective actors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and substance use disorders, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of emergency management/homeland security and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in behavioral health needs and/or impact persons with behavioral health conditions and their families and caregivers, providers of behavioral health services, and the state's ability to provide behavioral health services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in behavioral health.

Please consider the following items as a guide when preparing the description of the state's system:

1. Identify any existing partners and describe how the partners will support the state in implementing the priorities identified in the planning process.
2. Attach any letters of support indicating agreement with the description of roles and collaboration with the SSA/SMHA, including the state education authorities, the SMAs, entity(ies) responsible for health insurance and the health information Marketplace, adult and juvenile correctional authority(ies), public health authority (including the maternal and child health agency), and child welfare agency, etc.

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Not Required

Environmental Factors and Plan

22. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application

Narrative Question:

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council for adults with SMI or children with SED. To meet the needs of states that are integrating mental health and substance abuse agencies, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance abuse, referred to here as a Behavioral Health Advisory/Planning Council (BHPC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance abuse prevention and treatment advisory council to ensure that the council reviews issues and services for persons with, or at risk for, substance abuse and substance use disorders. To assist with implementing a BHPC, SAMHSA has created Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.[97]

Additionally, Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. 300x-51) applicable to the SABG and the MHBG, requires that, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

For SABG only - describe the steps the state took to make the public aware of the plan and allow for public comment.

For MHBG and integrated BHPC; States must include documentation that they shared their application and implementation report with the Planning Council; please also describe the steps the state took to make the public aware of the plan and allow for public comment.

SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

Please consider the following items as a guide when preparing the description of the state's system:

1. How was the Council actively involved in the state plan? Attach supporting documentation (e.g., meeting minutes, letters of support, etc.).
2. What mechanism does the state use to plan and implement substance abuse services?
3. Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work?
4. Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?
5. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders, and how it has advocated for individuals with SMI or SED.

Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.[98]

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[97] http://beta.samhsa.gov/grants/block-grants/resources

[98] There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

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

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

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

Environmental Factors and Plan

Behavioral Health Advisory Council Members

Start Year: 2016

End Year: 2017

Name	Type of Membership	Agency or Organization Represented	Address, Phone, and Fax	Email (if available)
Annabelle Payne	Providers	Pend Orielle County	105 S Garden Ave Newport, WA 99156 PH: 509-671-2323	apayne@pendoreille.org
Armando Herrerra	Family Members of Individuals in Recovery (to include family members of adults with SMI)		4524 NW 9 Circle Camas, WA 98607 PH: 360-844-5478	ADH777@comcast.net
Becky Bates	Providers		PH: 509-688-1124	bbates@passagesfs.org
Beth Dannhardt	Providers	Triumph Treatment Services	WA	bdannhardt@triumphtx.org
Carolyn Cox	Parents of children with SED		WA PH: 509-440-1142	carolyn.cox97@yahoo.com
Eleanor Owen	Family Members of Individuals in Recovery (to include family members of adults with SMI)		906 East Shelby St Seattle, WA 98102 PH: 206-322-0408	eleanor_owen@mindspring.com
Heather Maxwell	Others (Not State employees or providers)			heathermaxwell@thepacificimage.com
Jo Ellen Woodrow	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		11301 NE 7th St #NN10 Vancouver, WA 98684 PH: 509-701-4534	gem2005su@yahoo.com
Mark Freedman	Providers	Thurston Mason Regional Support Network	PH: 360-867-2558	freedmm@co.thurston.wa.us
Mary O'Brien	Providers	Yakima Valley Farm Workers	910 E. Mead Yakima, WA 98903 PH: 509-453-1344	mary@yvfwc.org
Phillip Gonzalez	Family Members of Individuals in Recovery (to include family members of adults with SMI)		16907 13th Ave Crt E Spanaway, WA 98387 PH: 253-531-5161	gonzapa@dshs.wa.gov
Steve Kutz	Federally Recognized Tribe Representatives		PH: 360-575-8277	skutz.health@cowlitz.org
Susan Kydd	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		4513 Lakeridge Dr E Lake Tapps, WA 98391 PH: 206-940-0339	susan.kydd@becu.org
Ron Hertel	State Employees	Office of Superintendent of Public Instruction	P.O. Box 47200 Olympia, WA 98504 PH: 360-725-6050	ron.hertel@k12.wa.us
Pamala Sacks-Lawlar	State Employees	Department of Social and Health Services/Juvenile Rehabilitation	PH: 360-902-0881	sackspa@dshs.wa.gov

Tory Clarke Henderson	State Employees	Department of Health	PH: 360-236-3522 FAX: 360-236-3646	tory.henderson@doh.wa.gov
Dan Halpin	State Employees	Office of the Insurance Commissioner	PH: 360-725-7218	danH@oic.wa.gov
Carmen Pacheco-Jones	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		16705 E Broadway Ave Spokane, WA 99037 PH: 509-294-8128	carmen.pacheco_jones@yahoo.com
Jeff Aldrich	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1830 Carpenter Rd Se, #7 Lacey, WA 98503 PH: 360-972-2336	supra2bcher@msn.com
Kimberly Miller	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		4525 113th Pl NE Marysville, WA 98271 PH: 360-913-3624	kimberly.miller.office@gmail.com
Kristina Sawyckyj-Moreland	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1830 9th Ave Seattle, WA 98101 PH: 206-501-7262	sawyckykristina@yahoo.com
Linda Kehoe, Ed.D	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		621 32nd St, #39 Bellingham, WA 98225 PH: 360-595-8547	drlindakehoe@yahoo.com
Moira O'Crotty	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		5832 S Oakes St Tacoma, WA 98409 PH: 253-365-2817	cmosnana@yahoo.com
Myra Paull	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		9601 Steilacoom Blvd W Lakewood, WA 98409 PH: 253-666-3242	mpaull@telecarecorp.com
Norrie Gregoire	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		455 West Rose Walla Walla, WA 99362 PH: 509-524-2822	ngregoire@co.walla-walla.wa.us
Sandra Koloske	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		28610 16th Ave S, #304 Federal Way, WA 98003 PH: 253-326-4073	sandiko@msn.com
Vanessa Lewis	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		6486 19th St W, #B Fircrest, WA 98466 PH: 253-830-4709	vlewis@wapave.org
Shelli Young	Providers	Snohomish County		shelli.young@snoco.org
Kristin West	Providers	Evergreen Council on Gambling	PH: 360-352-6133	kwest@evergreencpg.org

Footnotes:

Environmental Factors and Plan

Behavioral Health Council Composition by Member Type

Start Year: 2016

End Year: 2017

Type of Membership	Number	Percentage
Total Membership	35	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	12	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	3	
Parents of children with SED*	1	
Vacancies (Individuals and Family Members)	3	
Others (Not State employees or providers)	1	
Total Individuals in Recovery, Family Members & Others	20	57.14%
State Employees	4	
Providers	7	
Federally Recognized Tribe Representatives	1	
Vacancies	3	
Total State Employees & Providers	15	42.86%
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	3	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	1	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	4	
Persons in recovery from or providing treatment for or advocating for substance abuse services	1	

* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

Footnotes:

Substance Abuse and Mental Health Services Administration
SAMHSA
1 Choke Cherry Road • Rockville, MD 20857
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

JUL 6 2015

Ms. Chris Imhoff
Department of Social and Health Services
4500 10th Avenue SE
Lacey, WA 98503

Dear Ms. Imhoff:

The Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Services (CMHS) invites you to apply for the Mental Health Block Grant (MHBG) for federal fiscal year (FY) 2016. The FY 2016-2017 Uniform Application (0930-0168), which will serve as the application to the Secretary for the MHBG for FY 2016, must include funding agreements, assurances, certifications and planning tables for FY 2016.

The FY 2016-2017 Uniform Application is available electronically via the Block Grant Application System (Web-BGAS). An Adobe Acrobat version of the FY 2016-2017 Uniform Application may be downloaded from SAMHSA's block grant website. A copy of the authorizing legislation (42 USC § 300x-21 et seq) available on Web-BGAS under the Frequently Asked Questions section as well as SAMHSA's block grant website.

The FY 2016 Justification of Estimates for Appropriations Committees, includes a table of the estimated State/Territory allotments for the FY 2016 MHBG. However, a final FY 2016 Departments of Labor, Health and Human Services, Education (Labor-HHS-ED) and Related Agencies appropriations bill is pending. Upon enactment of the FY 2016 appropriations for Labor-HHS-ED and related agencies, a final allotment table for FY 2016 MHBG will be sent to you and uploaded on BGAS. In the interim, please refer to the enclosed FY 2016 MHBG allocation as authorized by the Consolidated Appropriations Act, 2016 (P.L. 112-74) for purposes of completing the FY 2016 Intended Use Plan (Table 7) and related planned expenditure checklists (Table 6 & Table 8).

All states and jurisdictions are required to prepare and submit their respective FY 2016-2017 Uniform Applications on or before September 1, 2015. All states and jurisdictions are required to execute the "Application Complete" function not later than Tuesday, September 1, 2015 at 11:59 p.m. EST. When a state or jurisdiction executes the "Application Complete" function, the Web-BGAS records "Application Completed by State User." This is SAMHSA's only evidence that a state or jurisdiction has complied with the statutory requirement regarding the September 1 receipt date.

Any state or jurisdiction planning to submit a combined FY2016-2017 Uniform Application must execute the "Application Complete" function not later than Tuesday, September 1, 2015 at 11:59 p.m. SAMHSA's block grant programs are subject to an annual audit pursuant to the Office of Management and Budget Circular A-123, "Management's Responsibility for Internal Controls," and one of the controls involves a review of how SAMHSA ensures states' and jurisdictions' compliance with the statutory receipt dates as described in sections 1917(a)(1) and 1932(a)(1) of Title XIX, Part B, Subpart I and Subpart II of the PHS Act, respectively.

The contact person for questions related to MHBG business management issues is:

Ms. Virginia Simmons
Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1109
Rockville, Maryland 20857
TEL. (240) 276-1422

Please submit a single copy of the Funding Agreements, Assurances Non-Construction Programs, Certification and Lobbying Disclosure Form, signed by the state's chief executive officer or designee, to SAMHSA and upload an electronic copy to Web-BGAS using the Attachments Tab. If one or more of the documents described above is signed by a designee, please include a current delegation of authority letter(s) from the state's chief executive officer. Forwarding any paperwork related to the FY 2016-2017 Uniform Application to any other addressee results in processing delays. To ensure express/overnight mail delivery, please use the following address:

Ms. Virginia Simmons
Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, 7-1109
Rockville, Maryland 20850
Telephone: (240) 276-1422

Questions of a fiscal or programmatic nature should be directed to your respective State Project Officer within CMHS's Division of State and Community Systems Development. Enclosed is a State project officer directory.

Sincerely,

Paolo del Vecchio, M.S.W.
Director
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration

cc: Sandra Mena-Tyree
Carrie Huie-Pascua

Enclosures:
2016 MHBG Prospective Allotments
MHBG Project Officer Directory