Washington

UNIFORM APPLICATION
FY2011

SUBSTANCE ABUSE PREVENTION AND TREATMENT
BLOCK GRANT

42 U.S.C.300x-21 through 300x-66

OMB - Approved 07/20/2010 - Expires 07/31/2013

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Substance Abuse and Mental Health Services Administration

Center for Substance Abuse Treatment

Center for Substance Abuse Prevention

Introduction:

The Substance Abuse Prevention and Treatment Block Grant represents a significant Federal contribution to the States' substance abuse prevention and treatment service budgets. The Public Health Service Act [42 USC 300x-21 through 300x-66] authorizes the Substance Abuse Prevention and Treatment Block Grant and specifies requirements attached to the use of these funds. The SAPT Block Grant funds are annually authorized under separate appropriation by Congress. The Public Health Service Act designates the Center for Substance Abuse Treatment and the Center for Substance Abuse Prevention as the entities responsible for administering the SAPT Block Grant program.

The SAPT Block Grant application format provides the means for States to comply with the reporting provisions of the Public Health Service Act (42 USC 300x-21-66), as implemented by the Interim Final Rule (45 CFR Part 96, part XI). With regard to the requirements for Goal 8, the Annual Synar Report format provides the means for States to comply with the reporting provisions of the Synar Amendment (Section 1926 of the Public Health Service Act), as implemented by the Tobacco Regulation for the SAPT Block Grant (45 CFR Part 96, part IV).

Public reporting burden for this collection of information is estimated to average 454 hours per respondent for Sections I-III, 40 hours per respondent for Section IV-A and 42.75 hours per respondent for Section IV-B, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to SAMHSA Reports Clearance Officer; Paperwork Reduction Project (OMB No. 0930-0080), 1 Choke Cherry Road, Room 7-1042, Rockville, Maryland 20857. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is OMB No. 0930-0080.

The Web Block Grant Application System (Web BGAS) has been developed to facilitate States' completion, submission and revision of their Block Grant application. The Web BGAS can be accessed via the World Wide Web at http://bgas.samhsa.gov.

Form 1

DUNS Number: 127347115-

Uniform Application for FY 2011-13 Substance Abuse Prevention and Treatment Block Grant

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

Agency Name:	Department of Social and Health Services	
Organizational Unit:	Div. of Behavioral Health and Recovery	
Mailing Address:	PO Box 45330	
City:	Olympia	Zip Code: 98504-5330

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

Name:	David Dickinson	
Agency Name:	Division of Behavioral Health and Recovery	
Mailing Address:	PO Box 45330	
City:	Olympia	Code: 98504-5330
Telephone:	360-725-3700	FAX: 360-586-9551
Email Address:	David.Dickinson@dshs.wa.gob	

III. State Expenditure Period:

From: 7/1/2008 To: 6/30/2009

IV. Date Submitted:

Date: 9/30/2009 4:18:24 PM Original: ◉ Revision: ○

V. Contact Person Responsible for Application Submission:

Name:	Sandra Mena-Tyree	Telephone:	360-725-3750
Email Address:	Sandra.Mena@dshs.wa.gov	FAX:	360-586-0341

Form 2 (Table of Contents)

FORM 3: UNIFORM APPLICATION FOR FY 2011 SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT
Funding Agreements/Certifications
as required by Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act

Title XIX, Part B, Subpart II and Subpart III of the PHS Act, as amended, requires the chief executive officer (or an authorized designee) of the applicant organization to certify that the State will comply with the following specific citations as summarized and set forth below, and with any regulations or guidelines issued in conjunction with this Subpart except as exempt by statute.

SAMHSA will accept a signature on this form as certification of agreement to comply with the cited provisions of the PHS Act. If signed by a designee, a copy of the designation must be attached.

I. Formula Grants to States, Section 1921

Grant funds will be expended "only for the purpose of planning, carrying out, and evaluating activities to prevent and treat substance abuse and for related activities" as authorized.

II. Certain Allocations, Section 1922

- **Allocations Regarding Primary Prevention Programs, Section 1922(a)**
- **Allocations Regarding Women, Section 1922(b)**

III. Intravenous Drug Abuse, Section 1923

- **Capacity of Treatment Programs, Section 1923(a)**
- **Outreach Regarding Intravenous Substance Abuse, Section 1923(b)**

IV. Requirements Regarding Tuberculosis and Human Immunodeficiency Virus, Section 1924

V. Group Homes for Recovering Substance Abusers, Section 1925
Optional beginning FY 2001 and subsequent fiscal years. Territories as described in Section 1925(c) are exempt.

The State "has established, and is providing for the ongoing operation of a revolving fund" in accordance with Section 1925 of the PHS Act, as amended. This requirement is now optional.

VI. State Law Regarding Sale of Tobacco Products to Individuals Under Age of 18, Section 1926

- **The State has a law in effect making it illegal to sell or distribute tobacco products to minors as provided in Section 1926 (a)(1).**
- **The State will enforce such law in a manner that can reasonably be expected to reduce the extent to which tobacco products are available to individuals under the age of 18 as provided in Section 1926 (b)(1).**
- **The State will conduct annual, random unannounced inspections as prescribed in Section 1926 (b)(2).**

VII. Treatment Services for Pregnant Women, Section 1927

The State "…will ensure that each pregnant woman in the State who seeks or is referred for and would benefit from such services is given preference in admission to treatment facilities receiving funds pursuant to the grant."

VIII. Additional Agreements, Section 1928

- **Improvement of Process for Appropriate Referrals for Treatment, Section 1928(a)**
- **Continuing Education, Section 1928(b)**
- **Coordination of Various Activities and Services, Section 1928(c)**
- **Waiver of Requirement, Section 1928(d)**

FORM 3: UNIFORM APPLICATION FOR FY 2011 SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT Funding Agreements/Certifications As required by Title XIX , Part B, Subpart II and Subpart III of the PHS Act (continued)
IX. Submission to Secretary of Statewide Assessment of Needs, Section 1929
X. Maintenance of Effort Regarding State Expenditures, Section 1930
With respect to the principal agency of a State, the State "will maintain aggregate State expenditures for authorized activities at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant."
XI. Restrictions on Expenditure of Grant, Section 1931
XII. Application for Grant; Approval of State Plan, Section 1932
XIII. Opportunity for Public Comment on State Plans, Section 1941
The plan required under Section 1932 will be made "public in such a manner as to facilitate comment from any person (including any Federal person or any other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary."
XIV. Requirement of Reports and Audits by States, Section 1942
XV. Additional Requirements, Section 1943
XVI. Prohibitions Regarding Receipt of Funds, Section 1946
XVII. Nondiscrimination, Section 1947
XVIII. Services Provided By Nongovernmental Organizations, Section 1955
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 Act, as amended, as summarized above, except for those Sections in the 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.
State: Washington
Name of Chief Executive Officer or Designee: Susan N. Dreyfus
Signature of CEO or Designee:
Title: Secretary **Date Signed:**
If signed by a designee, a copy of the designation must be attached

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 C.F.R. Part 76, and its principals:

(a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;

(b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and

(d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, In eligibility, and Voluntary Exclusion – Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with sub-grantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 C.F.R. Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 45 C.F.R. Part 76 by:

(a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

(b) Establishing an ongoing drug-free awareness program to inform employees about –
(1) The dangers of drug abuse in the workplace;
(2) The grantee's policy of maintaining a drug-free workplace;
(3) Any available drug counseling, rehabilitation, and employee assistance programs; and
(4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

(c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

(d) Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will –
(1) Abide by the terms of the statement; and
(2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

(e) Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

(f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted –

(1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or

(2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

(g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget
Department of Health and Human Services
200 Independence Avenue, S.W., Room 517-D
Washington, D.C. 20201

3. 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 C.F.R. Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the under signed, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities, "in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. 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 Public Health Service terms and conditions of award if a grant is awarded as a result of this application. **5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE** Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.	By signing the certification, the undersigned 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 subawards which contain provisions for children's services and that all subrecipients shall certify accordingly. The Public Health Service strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.
SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE Secretary
APPLICANT ORGANIZATION Department of Social and Health Services	DATE SUBMITTED

DISCLOSURE OF LOBBYING ACTIVITIES

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure.)

1. Type of Federal Action:

☐ a. contract
b. grant
c. cooperative agreement
d. loan
e. loan guarantee
f. loan insurance

2. Status of Federal Action

☐ a. bid/offer/application
b. initial award
c. post-award

3. Report Type:

☐ a. initial filing
b. material change

For Material Change Only:

Year _____ Quarter _____
date of last report

4. Name and Address of Reporting Entity:

☐ Prime ☐ Subawardee

Tier _____ , if known: _____

Congressional District, *if known:* _____

5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:

Congressional District, *if known:* _____

6. Federal Department/Agency:

7. Federal Program Name/Description:

CFDA Number, *if applicable:* _____

8. Federal Action Number, if known:

9. Award Amount, if known:

$

10. a. Name and Address of Lobbying Entity
(if individual, last name, first name, MI):

b. Individuals Performing Services *(including address if different from No. 10a.) (last name, first name, MI):*

11. Information requested through this form is authorized by title 31 U.S.C. Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Signature: _____

Print Name: _____

Title: _____

Telephone No.: _____ **Date:** _____

Federal Use Only:

Authorized for Local Reproduction
Standard Form - LLL (Rev. 7-97)

DISCLOSURE OF LOBBYING ACTIVITIES
CONTINUATION SHEET

Reporting Entity: **Page** **of**

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime Federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action. Use the SF-LLL-A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.

2. Identify the status of the covered Federal action.

3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.

4. Enter the full name, address, city, state and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.

5. If the organization filing the report in item 4 checks “subawardee”, then enter the full name, address, city, state and zip code of the prime Federal recipient. Include Congressional District, if known.

6. Enter the name of the Federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.

7. Enter the Federal program name or description for the covered Federal action (item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.

8. Enter the most appropriate Federal identifying number available for the Federal action identified in item 1 [e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal control number assigned by the Federal agency]. Include prefixes, e.g., ‘‘RFP-DE-90-001.’’

9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in item 4 or 5.

10. (a) Enter the full name, address, city, state and zip code of the lobbying entity engaged by the reporting entity identified in item 4 to influence the covered Federal action.

    (b) Enter the full names of the individual(s) performing services, and include full address if different from 10(a). Enter Last Name, First Name, and Middle Initial (MI).

11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (item 4) to the lobbying entity (item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

ASSURANCES – NON-CONSTRUCTION PROGRAMS

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

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

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L.88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

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 Coastal 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.

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.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE Secretary
APPLICANT ORGANIZATION Department of Social and Health Services	DATE SUBMITTED

1. Planning

THREE YEAR PLAN, ANNUAL REPORT, and PROGRESS REPORT:
PLAN FOR FY 2011-FY 2013 PROGRAM ACTIVITIES

This section documents the States plan to use the FY 2011 through FY 2013 Federal Substance Abuse Prevention and Treatment (SAPT) Block Grant. For each SAPT Block Grant award, the funds are available for obligation and expenditure for a 2-year period beginning on October 1 of the Federal Fiscal Year (FY) for which an award is made. States are encouraged to incorporate information on needs assessment, resource availability and States priorities in their plan to use these funds over the next three fiscal years. In the interim years (FY 2012 and FY 2013), updates to this 3-year plan are required; however, if the plan remains unchanged, additional narrative is not necessary. This section requires completion of needs assessment forms, services utilization forms and a narrative description of the States planning processes.

1. Planning

This section provides an opportunity to describe the State's planning processes and requires completion of needs assessment data forms, utilization information and a description of the State's priorities. In addition, this section provides the State the opportunity to complete a three year intended use plan for the periods of FY 2011-FY 2013. Finally this section requires completion of planning narratives and a checklist. These items address compliance with the following statutory requirements:

- 42 U.S.C. §300x-29, 45 C.F. R. §96.133 and 45 C.F.R. §96.122(g)(13) require the State to submit a Statewide assessment of need for both treatment and prevention.

The State is to develop a 3-year plan which covers the three (3) fiscal years from FFY 2011-FY 2013. In a narrative of **up to five pages,** describe:

- How your State carries out sub-State area planning and determines which areas have the highest incidence, prevalence, and greatest need.
- Include a definition of your State's sub-State planning areas (SPA).
- Identify what data is collected, how it is collected and how it is used in making these decisions.
- If there is a State, regional or local advisory council, describe their composition and their role in the planning process.
- Describe the monitoring process the State will use to assure that funded programs serve communities with the highest prevalence and need.
- Those States that have a State Epidemiological Outcomes Workgroup (SEOW) must describe its composition and contribution to the planning process for primary prevention and treatment planning. States are encouraged to utilize the epidemiological analyses and profiles to establish substance abuse prevention and treatment goals at the State level.

Describe how your State evaluates activities related to ongoing substance abuse prevention and treatment efforts, such as performance data, programs, policies and practices, and how this data is produced, synthesized and used for planning. A general narrative describing the States planned approach to using State and Federal resources should be included. For the prevention assessment, States should focus on the SEOW process. Describe State priorities and activities as they relate to addressing State and Federal priorities and requirements.

- 42 U.S.C. §300x-51 and 45 C.F. R. §96.123(a)(13) require the State to make the State plan public in such a manner as to facilitate public comment from any person during the development of the plan.

In a narrative of **up to two pages**, describe the process your State used to facilitate public comment in

developing the State's plan and its FY 2011-FY 2013 application for SAPT Block Grant funds.

For FY 2012 and FY 2013, only updates to the 3-year plan will be required. In the Section addressing the Federal Goals, the States will still need to provide Annual and Progress reports. Fiscal reporting requirements and performance data reporting will also be required annually.

The Prevention component of your Three Year Plan Should Include the Following:

Problem Assessment (Epidemiological Profile)

Using an array of appropriate data and information, describe the substance abuse-related problems in your State that you intend to address under Goal 2. **Describe the criteria and rationale for establishing primary prevention priorities.**

(See 45 C.F.R §96.133(a) (1))

Prevention System Assessment (Capacity and Infrastructure)
Describe the substance abuse prevention infrastructure in place at the State, sub-State, and local levels. Include in this description current capacity to collect, analyze, report, and use data to inform decision making; the number and nature of multi-sector partnerships at all levels, including broad-based community coalitions. In addition, describe the mechanisms the SSA has in place to support sub-recipients and community coalitions in implementing data-driven and evidence-based preventive interventions. If the State sets benchmarks, performance targets, or quantified objectives, describe the methods used by the State to establish these.

Prevention System Capacity Development
Describe planned changes to enhance the SSA's ability to develop, implement, and support—at all levels —processes for performance management to include: assessment, mobilization, and partnership development; implementation of evidence-based strategies; and evaluation. Describe the challenges associated with these changes, and the key resources the State will use to address these challenges. Provide an overview of key contextual and cultural conditions that impact the State's prevention capacity and functioning.

Implementation of a Data-Driven Prevention System
Describe the mechanism by which funding decisions are made and funds will be allocated. Explain how these mechanisms link funds to intended State outcomes. Provide an overview of any strategic prevention plans that exist at the State level, or which will be required at the sub-State or sub-recipient level, including goals, objectives, and/or outcomes. Indicate whether sub-recipients will be required to use evidence based programs and strategies. Describe the data collection and reporting requirements the State will use to monitor sub-recipient activities.

Evaluation of Primary Prevention Outcomes
Discuss the surveillance, monitoring, and evaluation activities the State will use to assess progress toward achieving its capacity development and substance abuse prevention performance targets. Describe the way in which evaluation results will be used to inform decision making processes and to modify implementation plans, including allocation decisions and performance targets.

Washington State Planning
2011-2013

Washington State provides funding to support chemical dependency outpatient treatment services to state residents through contracts with each of the 39 counties (substate Planning Areas-SPAs) and 29 federally recognized tribes. In some cases, due to geographic and fiscal reasons, counties combine to provide specific services. These combined counties are listed as distinct SPAs. Division of Behavioral Health and Recovery (DBHR) program managers, utilizing stakeholder input and variety of data resources, coordinate and monitor delivery of these services.

Where services necessarily cover a multi-county service area, services are provided on a statewide basis. This is primarily done for residential treatment services and for some statewide prevention efforts, especially those incorporating media and environmental strategies. With the exception of our most populous county, it is not practicable to provide residential treatment services county-by county. DBHR directly contracts with residential treatment agencies.

SPA plans for services utilize data provided from the biennial Healthy Youth Survey (which provides county and community-level information on youth substance abuse and attitudes), CORE-GIS (which provides community-level data on social indicators and risk and protective factors), and TARGET (Treatment and Assessment Report Generation Tool, which provides information on treatment admissions and discharges, and which is linked to other databases including criminal justice and medical and mental health services.) Other data are obtained from updates of a household survey on alcohol, tobacco, and other drug use, the state's Behavioral Risk Factor Surveillance Survey (BRFSS), and community-based focus groups.

Data Collection

DBHR collects client service data through two management information systems: TARGET and the Performance-Based Prevention System (PBPS).

All chemical dependency treatment providers are required to enter admission and discharge data into TARGET. TARGET data are retrievable at the state, regional, county, and program level, and include complete information on demographics, family and social arrangements, diagnosis, substances of abuse, modalities, and other information, as well as completion and outcome data. TARGET is linked with other statewide data bases to provide additional criminal justice and health-related information. Data is used to track trends, and inform planning decisions, allocation of resources, and recommendations to policymakers. With the merger between the Division of Alcohol and Substance Abuse and the Mental Health Division, new approaches to retrieving and managing client and provider data through a common data system. Efforts are underway to plan for effective use of these data systems to provide information necessary to ensure optimal treatment of co-occurring disorders.

DBHR's Performance-Based Prevention System (PBPS) provides data on all recurring prevention activities. Contractors are required to enter information related to participants and prevention activities. Pre- and post- surveys provide information on program effectiveness, which can then be used in further management and contracting decision-making. This data inform DBHR's regional prevention managers, who provide guidance and technical assistance to counties and communities, and SPAs in selecting evidence-based practices for use at the community level.

DBHR produces an annual Tobacco, Alcohol and Other Drug Abuse Trends in Washington State report. The Trends Report includes data from social service agencies, health agencies, law and justice agencies and educational institutions. Correlates of substance abuse include: birth defects and complications, accident risks, health complications, infectious diseases, crime violence, child abuse and other impacts on families. The Trends Report is made available to the counties for use in the development of their substance abuse needs assessment and county planning. Counties develop similar indicators on selected dimensions from local sources.
http://www.dshs.wa.gov/pdf/HRSA/DASA/2009%20Trends%20Report.pdf

Advisory Councils

Each county is required by statute to establish a County Administrative Board for Alcoholism and Substance Abuse. The administrative boards are appointed by boards of county commissioners (or county executive) and must broadly represent the community. The advisory councils are composed of up to 15 persons. The duty of the administrative boards is to advise the county commissioners in matters relating to county chemical dependency prevention and treatment services. The boards work with the county chemical dependency coordinator, who is a county employee and is the primary staff for the county chemical dependency program. The county coordinator, in conjunction with the board, prepares the county chemical dependency plan, develops the county chemical dependency budget, and selects subcontractors who will provide prevention and treatment services.

Public Comment on Use of Block Grant Funds

During the application period, a letter along with an overview of the block grant application is sent to all stakeholders inviting their review of Washington State Block Grant application. Citizens are instructed to the WebBGAS site and provide a username and password for read-only capabilities. Comments or questions are submitted by email to the Block Grant Manager.

Three Year Plan

With the advent of health care reform, over the next three years DBHR will strive to ensure the seamless integration of quality substance abuse-related services as part of an integrated health care delivery system. We will strive to:

- Develop a comprehensive, statewide needs assessment.
- Maintain a continuum of addictive disorder services to include prevention, intervention, treatment, and recovery support services.
- Expand and improve recovery-oriented systems of care.
- Reduce underage drinking.
- Develop the workforce.
- Facilitate health care reform implementation with staff and providers.
- Integrate mental health and chemical dependency services into a comprehensive behavioral health system.

Develop a comprehensive, statewide needs assessment

At a minimum, based on solid epidemiology, a needs assessment for substance abuse prevention, intervention and treatment must be based on the risk factors for and prevalence of substance use and substance use disorders. From a practical perspective, the assessment also should measure the availability and location of resources so that new or additional resources can be targeted or allocated more efficiently. Decisions to allocate those resources also should be balanced by considerations of workforce and provider capacity. Finally, policy considerations -- for instance, strategic priorities and legislative mandates -- are also incorporated into the assessment. Ideally, each of these steps has an empirical basis.

The process of completing and interpreting a needs assessment must proceed differently for treatment/recovery support and for prevention. In each case, the State Epidemiology and Outcomes Workgroup[1] (SEOW) will assess existing data; recommend how each source will be used; and, base recommendations based on those data. The SEOW will also make recommendations on which and how new data sources should be developed.

[1] The State Epidemiology and Outcomes Workgroup is made up of researchers and epidemiologists from each of the State's agencies tasked with monitoring and improving the health and outcomes of the population, as well as university researchers working in the substance abuse field.

The needs assessment for treatment and recovery will proceed step-wise, and will conclude with funding recommendation that:

1. Identify the people who are eligible for publicly funded services who need chemical dependency intervention, treatment, and/or recovery support services.
2. Determine how many of those individuals previously received (or are currently receiving) services.
3. Calculate the "unmet need" or "treatment gap" as the difference between those who need services and those who received services.
4. Allocate funding according to the overall rate of need, and adjust to increase funding in areas of significant unmet need among youth (who are more expensive to treat) and underserved populations.

This approach holds numerous challenges, some of which have short-term solutions. Overall, Washington State needs to develop new data capacity and new analytic procedures to complete a more finely detailed needs assessment. First, serious limitations exist with the National Survey on Drug Use and Health (NSDUH; OAS, 2010) that is often used as a source to estimate prevalence rates of substance use problems: obtaining sufficiently detailed information to allow sub-state geographic analyses or sub-population specific analyses is not possible. The second major concern is that the funding allocation is based primarily on historical funding levels. A funding formula was created in the past, based on population and existing treatment counts; however, the formula has not been updated in nearly ten years and the current funding, given severe economic stressors, is based on prior year funding. Our needs assessment process will adjust these allocations based on updated population and need data, with further enhancements based on specific unmet needs: people who are not DSHS clients, but are eligible for publicly funded treatment; those members of chronically underserved populations; and those populations identified as at high risk.

DBHR has established a sound methodology for estimating chemical dependency treatment need, among existing the Department of Social and Health Services clients (Sears et al, 2010). However, this estimate significantly and non-randomly undercounts the true population in need of treatment. For instance, those clients who have had difficulty or reluctance to engage with DSHS in the past are not counted (e.g., emancipated minors, single men with no children and without insurance, members of certain ethnic/cultural groups). Also, despite our data/analytic efforts, depending on the "entrance" to DSHS, some individuals might not be screened for substance use disorders and thus would not be flagged as being in need of treatment. To resolve this undercount, we will use the National Survey on Drug Use and Health (NSDUH) state estimates of the prevalence of alcohol and drug dependence. We will utilize a synthetic estimation process to determine treatment need within sub-state demographic and geographic groups. To ascertain which people need treatment and might be eligible for publicly funded services requires detailed knowledge of the poverty rate among demographic groups, but, in Washington, this currently does not exist at the geographic scale at which funding allocations are made.

The State's Office of Financial Management regularly updates projections of county populations by age, sex, race, and ethnicity. Based on those projections, we will develop a methodology that employs the American Community Survey information including poverty and health insurance rates by U.S. Census Public Use Microdata Area (PUMA) to estimate treatment need by county and demographic group. The resource assessment for treatment will be based on the location and capacity of existing service providers, relative to the residence of those in need of treatment.

As we work to refine the funding allocations, several issues must be taken into consideration: 1) In Washington, the average cost to treat an adolescent is considerably more than the cost to treat an adult and this needs to be considered in any funding formula; 2) Counties with significant unmet need for underserved populations must receive supplemental funding, beyond the average cost per person in need; and, 3) As we work with our SEOW, other significant disparities will be added as additional factors in funding allocations.

To refine our needs assessment for substance abuse prevention, we plan to proceed in a parallel fashion (step-wise, based on data, with the identification of underserved and high need populations). The data

sources and assumptions for prevention present different opportunities and challenges. (Intervention services, and especially early intervention for adolescents, will be based on a similar approach. See below.) Needs assessment of substance abuse prevention for children and youth will be based on the state's Healthy Youth Survey (HYS), which is administered biennially in 80% of schools. The survey includes a complete set of substance use indicators, risk and protective factors for substance use, as well as data on problem behaviors associated with substance use. Some of our new state priorities have been prompted by findings of the HYS. For example, after assessing non-quantitative surveillance information, in 2006 we developed and added a question on the illicit use of prescription opiates, and in 2008 added a question about the source of those drugs. Major state initiatives have been based on test data. In developing the Washington State SPF-SIG project, for example, the SEOW used HYS data and published reports on costs to society, and determined that our priority would be underage drinking. Using the school-level data, we identified all of the schools in the state where the drinking level of 8th graders was at least a standard deviation above the state average.

Starting with the extensive demographic data included in the HYS, the SEOW will complete a synthetic estimation of the need for prevention services in those populations that do not participate in the survey. For instance, from the HYS data we will know the rate of substance use among Hispanic youth living in rural counties, and will extrapolate those rates to Hispanic populations in rural school districts that do *not* participate in the survey. The needs assessment will include a prioritization approach approved by the SEOW that balances the need for prevention among DSHS clients (those in high poverty neighborhoods or among high risk population groups) and the cost to the state of behaviors associated with youth substance use.

The assessment of need for youth intervention services will also be based on the HYS data. Those intervention services that are best located in schools can be placed according to high rates of substance use and associated problem behaviors, as measured by the survey. But the needs assessment also will be enhanced by incorporating information on the distribution of high risk associated with families of substance abusers and neighborhoods of high poverty or high density of DSHS clients.

Prevention and intervention with young adult populations present special challenges. A literature review supported by the SEOW has identified risk factors associated with different subpopulations of young adults. However, neither of the extant sources of data (the NSDUH and the Behavioral Risk Factor and Surveillance System (BRFSS), have adequate data for this age group to help us allocate resources accordingly. The SEOW had recommended an expansion of our data collection using the BRFSS but funding cuts have reduced the sample so that only state-level estimates will be produced.
The State of Washington has made considerable efforts regarding implementing Screening and Briefing Interventions (SBI) in a variety of settings, as a means to address need for services beyond prevention or treatment. These efforts started with the WASBIRT (Washington Screening, Brief Intervention, and Referral to Treatment) grant and have since expanded to facility-funded SBI programs in a variety of Emergency Departments, some new initiatives to include SBI in primary care offices and dental clinics. SBI has been incorporated into state certification regulations and we are looking to include it in the State Plan for Medicaid reimbursement.

The resource assessment for prevention services is far more complex because many public and private agencies deliver services that fit into specific areas of prevention needs and none of these are reported consistently. One goal of the needs assessment is to continue our efforts to coordinate data collection and to share the details of prevention services in the State.

Prevention Component

Problem Assessment (Epidemiological Profile)

Statewide student survey results, indicators of risk and protective factors, publicly and privately-funded substance abuse treatment as well as other databases dealing with DSHS clients, led Washington to select the seven State Priorities mentioned earlier for its Substance Abuse Prevention and Treatment Block Grant for FFY 2011-2013.

Primary prevention priorities

The overall statewide prevention priority is to "Reduce underage drinking." This was determined through an epidemiological review undertaken as part of the federal State Prevention Framework-State Incentive Grant, which examined prevalence and trends, demographics and geographic spread, costs to society, and community readiness to address the problem.

Youth younger than 18 years old

Though public attention can sometimes become focused on use by youth of drugs other than alcohol and tobacco, it is those two drugs that are most available to youth and most commonly used. The percentage of 30-day use of alcohol among 10th graders declined from 1998-2008. During that period of time, the state has also seen reductions in tobacco use, with self-reported current smoking dropping from 25 percent to 14.4 percent for 10th graders. However, the decreases in the 30-day use rate of alcohol have leveled off significantly and now there are indications that alcohol use by 18-24 year olds is increasing. In 2008, the State Epidemiology Workgroup (SEW) concluded that 21 percent of 10th graders fall into the high-risk drinking composite category.

Young adults, 18-24 years old

Using data from the CDC's Behavioral Risk Factor Surveillance Survey and the Healthy Youth Servury Washington State young adults ages 18-24 participate in binge drinking behavior (five drinks or more in one setting) more often than 10th and 12th graders, and almost twice as often as adults ages 35-64.

Prevention System Assessment (Capacity and Infrastructure)

Counties: Counties developed six-year strategic plans in 2007 for providing services across the PITR continuum of substance abuse services (Prevention, Intervention, Treatment, and Recovery Support Services). They used the five-step Strategic Prevention Framework planning framework to develop their six-year plans. They developed a prioritized list of needs and gaps based on an assessment of the current level of need (elevated risk factors), resources available to address the needs, and identified and prioritized gaps.

Tribes: Funds allocated by DBHR to tribes can be spent on substance abuse treatment or prevention services, or split between the two categories. Tribes using their funds for prevention are required to work with regional prevention managers to develop plans to serve prioritized populations in their communities.

Statewide services: The array of statewide services includes support of a statewide prevention/intervention program administered through the state's Office of Superintendent of Public Instruction, an annual statewide Prevention Summit, and a statewide Alcohol and Drug Clearinghouse.

Since 2005, DBHR has monitored the performance of prevention efforts through its regional prevention managers and through its online PBPS reporting system. The regional prevention managers provide guidance and technical assistance regarding the assessment processes, identification of priorities, development of community capacity, selection of strategies, and evaluation of impact. The regional prevention managers also review submitted plans and monitor performance of sub-contractors.

Prevention System Capacity Development

DBHR has begun a Prevention Re-Design Initiative (PRI) so that services can be planned at the community level. Most counties presently serve multiple communities and few of the communities have adequate resources to make community-level change. Under prevention system re-design, counties will be required to use funds in specific communities, rather than countywide, based on an assessment of need. The change will better allow DBHR to demonstrate community-level outcomes.

The proposed redesign initiative is not without significant challenges. These include: 1) the State's concurrent efforts to integrate substance abuse services, mental health, and physical health services; 2) access to adequate funding and resources; and, 3) workforce knowledge and skill sets. However, by involving all stakeholders in the PRI process, and by continuing to use data to drive decision-making, the State stands to come out of the process with a more streamlined, more cost-effective, and more performance-based prevention system.

The PRI will be phased in over a three-year period. Minimum expectations and key objective benchmarks will be established and monitored, and technical assistance provided. To date, 13 counties, representing 20 communities, have been chosen for the first phase of implementation.

Implementation of a Data-Driven Prevention System

Currently, funding levels for county and tribal prevention providers are based largely on a funding formula. The funding formula guarantees a base funding amount of $60,000 per biennium for each county, regardless of size. The funding is increased based on the population of the county. King County – with the state's largest city of Seattle, receives the largest single allocation through the block grant. DBHR began providing federal Block Grant funding to the 29 federally recognized tribes in Washington in 2000. Because of the tribes' status as sovereign nations, funding allocations are negotiated through a Government-to-Government contracting process. Tribes can use their allocated funds to provide prevention services, treatment services, or a combination of both.

In 2000, the state's first Substance Abuse Prevention Plan was developed in connection with the first prevention state incentive grant and was supported by 12 state agencies and boards. In 2010, Washington State updated its strategic plan for reducing underage drinking. The Department of Health updated its statewide tobacco prevention plan in 2007 and it contains key provisions such as reducing youth access to tobacco and implementing the annual Synar survey required by the SAPT Block Brant.

DBHR requires counties to utilize a minimum of 50 percent evidence-based prevention programs and strategies. In FFY2009, 69 percent of programs and strategies implemented by counties were evidence-based and nearly. We expect this percentage to continue to rise modestly in FFY 2011-2013.

Evaluation of Primary Prevention Outcomes

In FFY 2011-2013, Washington State expects to continue contracting with KIT Solution for web-based reporting system (PBPS) used by all DBHR prevention contractors funded through the Block Grant. The PBPS collects planning, administrative, service, and outcome data for all billable prevention services. Providers are contractually obligated to report by the 15th of the month following the date of service on all required fields. Several changes during the past two years have increased the usefulness of the collected data for evaluation purposes. These included: adding service location addresses, residence zip code has been added to the client demographic information, and expanded use of outcome survey instruments for all participants in recurring services who are age 10 or older as of the first date of service. In FFY 2011-201, we expect to make other changes as needed to increase PBPS's usefulness both to providers and to the state.

Maintain a continuum of addictive disorder services to include prevention, intervention, treatment and recovery supports.

Even in the difficult budgetary climate of Washington State, DBHR has managed thus far to maintain a full continuum of prevention, intervention, treatment, and recovery support services.

Block Grant funds in FFY 2011-2013 will support primary prevention, patients in adult residential programs under the Alcoholism and Drug Addiction Treatment and Support Act (ADATSA, the state's chemical dependency support program for indigent person who are unable to work because of their addiction), housing support services, and outpatient treatment (including opiate substitution treatment) and ancillary services (i.e., transportation, childcare, interpreter services.) DBHR does not provide direct

services. As already noted, funding for outpatient services will be contracted through counties and tribe, and is based on population and treatment need. There are 39 counties and 29 tribes located within six regions and managed by three regional administrators. Tribal programs provide services mostly to the tribal populations; however, they do have the option of serving non-tribal members as well. Each county has been responsible for submitting a strategic plan based on local needs, taking account of state-mandated and federal priorities. Tribes will be required to do the same for the 2011-2013 contracts.

Expand and improve a recovery-oriented system of care.

DBHR recognizes that, in addition to treatment, recovery support services are important adjuncts in helping ensure individuals can move toward health lifestyles and return to active, productive lives in their families and communities. Critical to the delivery of these services is embedding them with a recovery-oriented system of care in which clients can identify and prioritize realistic goals and steps to meet them, and select those services which they believe can aid them on the path to recovery.

Washington State is the national leader in number of Oxford Houses, with 222 houses and more than 1,900 beds. These resident-run, cooperative houses provide stable, post-treatment housing to individuals who participate in recovery programs. DBHR expects to assist in the continued expansion of Oxford Houses in FFY 2011-2013. More detail can be found in Goal 7.

Through its Safe Babies Safe Moms program, DBHR annually provides services to approximately 250 substance-abusing pregnant, postpartum, and parenting women and their children from birth-to-three. A specialized Targeted Intensive Case Management (TICM) multidisciplinary team serves each site, providing assistance in accessing local resources, including family planning, safe housing, health care, domestic violence services, parenting skills training, child welfare, childcare, transportation, and legal services. Mental health screening, assessment, and treatment are provided as appropriate. Following chemical dependency treatment, housing support services are provided, with transitional drug-free housing provided for up to 18 months. DBHR expect to maintain this program in FFY 2011-20-13

Through two successive federal grants, Washington's Access to Recovery (ATR) program provides recovery services to individuals and families in six Washington counties. These services include: mental health counseling, medical and dental care, preventive services for family members, childcare, transportation, employment and housing assistance. ATR is consumer-driven, with patients selecting from a menu of services e they believe are most critical in aiding them on the path to recovery. A Washington State study indicates that clients who receive ATR services remain in treatment longer, are more likely to complete treatment, are more likely to become employed, and have lower medical costs than similar clients who do not receive ATR services. DBHR is hoping to expand ATR-like recovery support services to additional Washington counties with state funding and an additional federal grant.

Develop the workforce.

DBHR expects to maintain and, within available funds, expand its Community Prevention Training (CPT) initiative that provides financial support to county governments to increase their capacity to utilize evidence-based prevention practices (EBPs). Substance Abuse Prevention Specialists Training will instruct local local providers how to best plan for prevention services to achieve optimum outcomes, including both risk and protective factors and prevalence measures.

DBHR plans to provide training and continuing education opportunities to more than 1,750 substance abuse professionals each year in FFY 2011-2013. These opportunities, provided through statewide conferences and local and regional trainings, utilize a coordinated approach to address and promote workforce development and provide effective and high-quality clinical training. Trainings are designed to meet either specific needs as identified through counties strategic plans or are linked to statewide priorities or needs assessments. It is expected there will be at least three statewide conferences each year: The Prevention Summit; Co-Occurring Disorders and Treatment Conference: and the "Saying It Out

Loud" conference (which addresses the specific needs of sexual minorities.) More detail can be found in Goal 11.

Training in the treatment field will emphasizes the use of common screening instruments for substance abuse and mental health disorders, and training to address the needs of patients with co-occurring disorders. In addition, given the requirements of health care reform, workforce efforts will address the need for coordination/collaboration between the treatment field and primary care organizations.

In addition, DBHR has begun to offer training to providers regarding potential opportunities to provide chemical dependency treatment under health reform. The role of chemical dependency treatment within Accountable Care Organizations (ACOs) is being explored, especially as the Washington State Legislature has recently authorized two pilot ACO projects. It is expected that this training will continue in FFY 2011-2013.

Planning Checklist

Criteria for Allocating Funds

Use the following checklist to indicate the criteria your State will use how to allocate FY 2011-2013 Block Grant funds. Mark all criteria that apply. Indicate the priority of the criteria by placing numbers in the boxes. For example, if the most important criterion is 'incidence and prevalence levels', put a '1' in the box beside that option. If two or more criteria are equal, assign them the same number.

1 Population levels, Specify formula:

Per County (SPA) Allocation

2 Incidence and prevalence levels

3 Problem levels as estimated by alcohol/drug-related crime statistics

3 Problem levels as estimated by alcohol/drug-related health statistics

3 Problem levels as estimated by social indicator data

3 Problem levels as estimated by expert opinion

1 Resource levels as determined by (specify method)

Federal and State Priorities

2 Size of gaps between resources (as measured by)

Client Admissions

and needs (as estimated by)

Needs Survey Data

Other (specify method)

Form 4 (formerly Form 8)

Treatment Needs Assessment Summary Matrix

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2008 6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
Adams County	12,087	1,266	380	0	0	366	110	144	83	0	0	0	0

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2008 6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
Asotin County	16,744	1,777	533	27	8	594	178	131	70	0	0	0	0

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2008 6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
Benton County	116,809	12,466	3,740	137	41	4,203	1,261	784	1,070	0	0	0	0

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2008 6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
Chelan County	54,333	5,648	1,694	174	52	1,794	538	272	361	0	16.60	0	0

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2008 6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
Clallam County	52,684	4,967	1,490	107	32	1,703	511	221	242	0	10.10	0	0

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2008 6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek	A. Needing treatment services	B. That would seek	A. Needing treatment services	B. That would seek	A. Number of DWI	B. Number of drug-	C. Other:	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000

			treatment		treatment		treatment	arrests	related arrests				
Clark County	307,567	33,095	9,928	1,226	368	11,351	3,405	732	1,094	0	18.90	4	1.70

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2008 6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
Columbia County	3,194	308	93	4	1	96	29	12	11	0	0	0	0

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2008 6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
Cowlitz County	77,768	8,407	2,522	337	101	2,797	839	415	429	0	11.10	8.10	0

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2008 6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
Douglas County	27,671	2,919	876	4	1	940	282	137	98	0	0	0	0

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2008 6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
Ferry County	6,243	700	210	14	4	227	68	27	15	0	0	0	0

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2008 6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
Franklin County	37,154	3,898	1,169	70	21	1,125	337	379	341	0	0	7.10	0

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2008 6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek	A. Needing treatment services	B. That would seek	A. Needing treatment services	B. That would seek	A. Number of DWI	B. Number of drug-	C. Other:	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000

			treatment		treatment		treatment	arrests	related arrests				
Garfield County	1,922	196	59	4	1	60	18	16	15	0	0	0	0

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2008 6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
Grant County	59,295	6,493	1,948	10	3	1,956	587	310	373	0	0	0	0

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2008 6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
Grays Harbor	52,922	5,771	1,731	190	57	1,862	559	301	580	0	7.10	8.50	0

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2008 6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
Island County	60,006	5,818	1,746	27	8	1,909	573	346	221	0	11.30	0	0

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2008 6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
Jefferson County	24,893	2,159	648	24	7	703	211	115	137	0	0	0	0

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2008 6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
King County	1,445,145	149,717	44,915	8,172	2,454	50,362	15,108	3,861	4,095	0	47.70	16.90	6.40

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2008 6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek	A. Needing treatment services	B. That would seek	A. Needing treatment services	B. That would seek	A. Number of DWI	B. Number of drug-	C. Other:	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000

			treatment		treatment		treatment	arrests	related arrests				
Kitsap County	187,105	19,692	5,908	307	92	6,647	1,994	737	903	0	11.30	2.40	2

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2008 6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
Kittitas County	27,083	3,317	995	14	4	1,056	317	242	321	0	17.80	0	0

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2008 6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
Klickitat County	15,803	1,590	477	14	4	516	155	107	94	0	0	0	0

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2008 6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
Lewis County	56,766	6,054	1,816	147	44	1,982	595	147	333	0	0	0	0

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2005 6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
Lincoln County	7,968	774	232	7	2	253	76	25	40	0	0	0	0

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2008 6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
Mason County	42,334	4,058	1,217	74	22	1,354	406	227	329	0	14.20	12.40	0

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2008 6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek	A. Needing treatment services	B. That would seek	A. Needing treatment services	B. That would seek	A. Number of DWI	B. Number of drug-	C. Other:	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000

			treatment		treatment		treatment	arrests	related arrests				
Okanogan County	32,173	3,376	1,013	7	2	1,093	328	174	101	0	12.50	0	0

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2008 6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
Pacific County	17,255	1,530	459	44	13	490	147	89	75	0	2,735	0	0

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2008 6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
Pend Orielle County	10,199	1,027	308	4	1	334	100	70	38	0	0	0	0

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2008 6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
Pierce	569,323	60,416	18,125	2,282	685	20,714	6,214	2,323	2,970	0	13.80	7.90	2.50

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2008 6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
San Juan County	14,096	1,199	360	7	2	398	119	87	19	0	0	0	0

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2008 6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
Skagit County	89,749	9,301	2,790	517	155	3,087	926	428	444	0	7.70	4.30	0

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2008 6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing	B. That	A. Needing	B. That	A. Needing	B. That	A. Number	B. Number	C. Other:	A. Hepatitis	B. AIDS/	C. Tuberculosis

		treatment services	would seek treatment	treatment services	would seek treatment	treatment services	would seek treatment	of DWI arrests	of drug-related arrests		B /100,000	100,000	/100,000
Skamina County	8,201	860	258	14	4	278	83	112	92	0	0	0	0

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2008 6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
Snohomish County	527,829	55,896	16,769	1,296	389	19,157	5,747	1,716	1,809	0	35.90	4.90	3.60

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2008 6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
Spokane County	337,141	37,881	11,964	1,755	527	12,587	3,776	227	1,141	0	16.30	5.70	1.70

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2008 6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
Stevens County	33,888	3,623	1,087	34	10	1,182	355	78	189	0	0	0	0

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2008 6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
Thurston County	189,650	19,785	5,927	690	207	6,827	2,046	545	567	0	20.40	3.70	2

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2008 6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
Wahkiakum County	3,196	294	88	4	1	97	29	7	0	0	0	0	0

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2008 6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment	B. That would	A. Needing treatment	B. That would	A. Needing treatment	B. That would	A. Number of	B. Number of	C. Other:	A. Hepatitis B	B. AIDS/ 100,000	C. Tuberculosis /100,000

		treatment services	would seek treatment	treatment services	would seek treatment	treatment services	would seek treatment	of DWI arrests	of drug-related arrests		B /100,000	100,000	/100,000
Walla Walla County	40,709	4,333	1,300	27	8	1,339	402	151	109	0	0	0	0

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2008 6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
Whatcom County	143,855	16,944	5,083	237	71	5,464	1,639	640	914	0	12	5.20	2.60

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2008 6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
Whitman County	28,959	4,067	1,220	4	1	1,260	378	254	216	0	0	0	0

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2008 6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
Yakima County	162,352	17,177	5,153	1,026	308	5,429	1,629	1,176	932	0	2.50	5.10	4.70

Form 5 (formerly Form 9)

Treatment Needs by Age, Sex, and Race/ Ethnicity

AGE GROUP	A. Total	B. White		C. Black or African American		D. Native Hawaiian / Other Pacific Islander		E. Asian		F. American Indian / Alaska Native		G. More than one race reported		H. Unknown		I. Not Hispanic Or Latino		J. Hispanic Or Latino	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
17 Years Old and Under	45,792	21,037	14,529	1,172	488	196	129	638	264	1,023	962	2,917	2,437	0	0	23,828	16,748	3,325	1,888
18 - 24 Years Old	133,377	73,347	33,795	4,057	606	1,584	1,088	1,715	1,619	1,900	830	3,838	4,439	2,792	1,767	75,930	41,079	13,304	3,066
25 - 44 Years Old	244,903	132,084	77,258	5,224	2,670	847	607	4,290	2,301	2,912	3,349	4,316	2,797	6,248	0	142,464	84,172	13,455	4,811
45 - 64 Years Old	124,531	78,514	27,254	3,010	530	387	129	1,261	674	1,404	1,100	2,174	630	4,915	2,549	89,705	31,655	1,960	1,177
65 and Over	15,410	5,640	5,562	143	0	0	0	150	654	0	0	212	0	1,859	1,190	7,808	7,406	195	0
Total	564,013	310,622	158,398	13,606	4,294	3,014	1,953	8,054	5,512	7,239	6,241	13,457	10,303	15,814	5,506	339,735	181,060	32,239	10,942

Persons under age 12 are omitted from Form 5.
(9) To estimate treatment need among youth, Reseach and Data Analysis used the latest published Washington State specific alcohol/drug abuse/dependence measures from the NSDUH to estimate statewide treatment need among youth aged 12-17 (pooled 2006-07); and used administrative data indicators of alcohol/drug treatment need to allocate the NSDUH statewide estimate of need across race, ethnicity, and gender groups.

Separate adjustment ratios were employed due to slight differences in race/ethnicity distribution of the Washington Department of Social and Health Services medical population, relative to the statewide population of youth aged 12-17.
The treatment need rate among Native Hawaiians and other Pacific Islanders (NHOPI) was estimated using the WANAHS II current need for treatment prevalence rate for low-income adults, relative to the statewide average (13.8% for NHOPI relative to 13.6% statewide average for low-income adults).

The basis for these estimates was constructed from the 2003 Washington State Needs Assessment and Household Survey (WANAHS II). The population matrix contains counts of adult persons ages 18 and over in demographic groups defined by age, gender, race/ethnicity, and poverty status. Population estimates were obtained from the 2000 U.S. Census, and adjusted to reflect population growth to 2008 using estimates from the 2008 Population Trends as developed by the Washington State Office of Financial Management.
The overall total and totals by gender, race and ethnicity are composite sums of the age groupings developed by the two aforedescribed processes (i.e., including persons aged 12-17, 18-24, 25-44, 45-64, and 65 and over).
Due to rounding, race and ethnicity numbers may not sum exactly to the statewide total (note that the total in Column B might be duplicated, due to individuals reporting more than one race).

Population estimates for the adult population were obtained from the 2000 U.S. Census, and adjusted to reflect population growth to 2008 using estimates from the 2008 Population Trends as developed by the Washington StateO ffice of Financial Management.
Data on youth population was obtained from the Washington State Population Estimates for Public Health for Calendar Year 2008, as developed by the Washington State Department of Health, in conjunction with the Vista Partnership and Krupski
Consulting.

How your State determined the estimates for Form 4 and Form 5 (formerly Form 8 and Form 9)

How your State determined the estimates for Form 4 and Form 5 (formerly Form 8 and Form 9)

Under 42 U.S.C. §300x-29 and 45 C.F.R. §96.133, States are required to submit annually a needs assessment. This requirement is not contingent on the receipt of Federal needs assessment resources. States are required to use the best available data. Using **up to three pages**, explain what methods your State used to estimate the numbers of people in need of substance abuse treatment services, the biases of the data, and how the State intends to improve the reliability and validity of the data. Also indicate the sources and dates or timeframes for the data used in making these estimates reported in both Forms 4 and 5. This discussion should briefly describe how needs assessment data and performance data is used in prioritization of State service needs and informs the planning process to address such needs. The specific priorities that the State has established should be reported in Form 7. State priorities should include, but are not limited to the set of Federal program goals specified in the Public Health Service Act. In addition, provide any necessary explanation of the way your State records data or interprets the indices in columns 6 and 7, Form 4.

On Data Reliability and Validity for Forms 4 and 5

The Division of Behavioral Health and Recovery (DBHR) currently has procedures containing various business decision rules and/or approaches that direct the development and maintenance of data within its reporting environment. DBHR also maintains working relationships with external partners to facilitate information and data exchange – these outside entities employ strict guidelines to ensure integrity and reliability within their data systems (Note the annotations in small bolded print for technical notes related to third party source data.). The state has a agency-wide group, the Data Analytic Workgroup, that includes researchers, analysts, and database managers from substance abuse and mental health program offices and the shared services Information Technology group. This group meets every other week to further develop the principles, guidelines, and procedures to improve the quality (accuracy, reliability, and timeliness) of the data, analytic procedures, and reporting. This process for data improvement is ongoing and we see significant improvement to our internal processes. There is also a division/stakeholder workgroup that meets bimonthly (the Systems Improvement Workgroup) to work on quality improvement projects. One of the issues that continues to be a focus is the quality and adequacy of the data submitted by the providers, and improving the analyses and reporting of performance and outcome measures. Finally, both the TARGET Advisory Committee meets regularly to improve the quality of the key treatment data systems, bi-directionally. For our prevention data system (PBPS), there are monthly webinars for users to confer with DBHR staff on recent changes, updated reports, and tips on how to better use the system. DBHR plans to continue all of these efforts in the coming years. We also use internal reports to track the completeness, timeliness, and quality of the data coming into our system and use those reports to determine technical assistance needs in the field. We also hold regular training on the data and reporting systems to allow for any turnover in field staff.

The needs assessment process that Washington State is planning is described in detail in Goal #13 (see or page XXXX). As described in Goal #13, we intend to use the data and analyses from that process in prioritizing State service needs and informing the planning process to address the identified needs.

For more information on data administration procedures, refer to Goal #13.

How Estimates for Forms 4 and 5 were Determined

Form 4

Total Population (Section 2)

Population estimates were obtained from the 2000 U.S. Census, and adjusted to reflect population growth to Calendar Year 2008 using estimates from the 2008 Population Trends as developed by the Washington State Office of Financial Management (updated August 2009). Population estimates include all age groupings of individuals ages 18 and older.

Total Population Needing Treatment Services (Section 3a)

Estimated counts by county of individuals in need of treatment services were determined via a synthetic estimation process conducted by the Washington State DSHS Research and Data Analysis Division (RDA). The basis for these estimates was constructed from the 2003 Washington State Needs Assessment and Household Survey (WANAHS II). To derive county estimates for the need for substance abuse treatment from the statewide Household Survey, it was necessary to construct a demographically specified population matrix for each county against which the statewide survey-based prevalence rates could be applied. The population matrix contained counts of persons in demographic groups defined by age, gender, race/ethnicity, and poverty status. Population estimates were obtained from the 2000 U.S.

Census, and adjusted to reflect population growth to Calendar Year 2008 using estimates from the 2008 Population Trends as developed by the Washington State Office of Financial Management (updated August 2009).

Estimates of need are for adult household residents (i.e., individuals ages 18 and over), and do not include individuals under age 18, or institutionalized (e.g., incarcerated) adults.

Differences between counties in estimated rates of need for treatment result from differences in the demography of the counties. For example, counties with higher proportions of young adults will have higher estimated rates of need for treatment than counties with lower proportions of young adults, because young adults are more likely to have a current need for treatment. This method of developing county prevalence estimates from statewide prevalence rates is called synthetic estimation.

That Would Seek Treatment (Sections 3b, 4b, 5b)

The estimated number of the total persons in need of treatment that would seek treatment is based on an assumption that, without economic, legal or other incentives, beside the availability of treatment on demand, no more than 30% of the population in need would access services. According to the 2003 WANAHS II, 26.2 percent of eligible persons needing treatment actually received it. The assumption is that those who qualified and sought treatment would receive it. Therefore, each of the values within Sections 3b, 4b, and 5b are estimated by multiplying, by county, each of the values within Sections 3a, 4a, and 5a by a factor of 0.3.

Intravenous Drug Users (IVDUs) in Need of Treatment (Section 4a)
Based on the assumption that those in treatment reflect approximately 30% of the total IVDU population at any given time, values for IVDUs in need of treatment were estimated by multiplying, by county, the actual number of individuals in treatment during Calendar Year 2008 (as reported in the Treatment and Assessment Generation Reporting Tool [TARGET], the database housing administrative, client and service encounter data on chemical dependency treatment services) who had reported at admission that they had recently used needles, by a factor of 3.33. This factor is based on a Division of Behavioral Health and Recovery analysis of utilization and treatment penetration rates. Counts are duplicated across counties and therefore do not add up to the statewide unduplicated total.

Number of Women Needing Treatment Services (Section 5a)

These data were developed from a process of synthetic estimation conducted by the Washington State RDA, based on the 2003 WANAHS II. The number of women in need was obtained by multiplying the estimated need for treatment among women by the population estimate of women, by county. Estimates of need for women are for adult (ages 18 and over) household residents during the period of Calendar Year 2008, and do not include individuals under age 18, or institutionalized (e.g., incarcerated) adults.

Arrests for Driving Under the Influence (DUI) and Drug-Related Arrests (Sections 6a and 6b)

All values for DUI and Drug-Related arrests for each county were obtained from Calendar Year 2008 annual adult (ages 18 and older) and juvenile (ages 10 to 17) arrest data provided by the Washington Association of Sheriffs and Police Chiefs. The statewide total (not included in the table) is an aggregate of arrests by the Washington State Patrol on Washington highways. Because the statewide total is in addition to the sum of the individual counties, it cannot be rolled up into the county data (substate planning areas).

For definition purposes, DUI means the driving or operating of any vehicle or common carrier while drunk or under the influence of liquor or narcotics. This includes operating a motor vehicle, engine, train, streetcar, boat, etc., while intoxicated.

Drug-Related Arrests include the transgression of state and local laws relating to the unlawful possession, sale, use, growing, manufacturing, and making of narcotic drugs.

Communicable Diseases (Section 7)

Values for combined county areas (e.g., Benton-Franklin, Chelan-Douglas, Thurston-Mason) are reported separately for each county. Counts of incidence rates cover the index or reference year, whereby the source data come directly from the Washington State Department of Health (DOH) Communicable Disease Program.

Population estimates were obtained from the 2000 U.S. Census, and adjusted to reflect population growth to 2008 using Washington State Population Estimates for Public Health for Calendar Year 2008, as developed by the Washington State Department of Health, in conjunction with the Vista Partnership and Krupski Consulting. The population estimates closely comport with the estimates from the 2008 Population Trends as developed by the Washington State Office of Financial Management (updated August 2009). Population counts used in calculating the incidence rate per 100,000 include all age groupings.

Hepatitis B (Section 7a)

Counts of acute Hepatitis B were obtained from statewide Calendar Year 2008 Acute Hepatitis B Incidence Rates data from the Washington State Department of Health Communicable Disease Program website; and by monthly DOH surveillance reports by county of epidemiologic trends and morbidity.

(http://www.doh.wa.gov/notify/nc/hepb.htm)
(http://www.doh.wa.gov/EHSPHL/epitrends/08-epitrends/2008_trend.htm).

Counts of viral, chronic Hepatitis B were obtained from statewide Calendar Year 2008 Chronic Hepatitis B Incidence Rates surveillance data collected by the Infectious Disease and Reproductive Health Assessment Unit of the Washington State Department of Health (DOH).

These counts included cases of individuals of all ages covering Calendar Year 2008, by county. The composite sum of acute and chronic Hepatitis B cases in each county was used in calculating the incidence rate per 100,000 persons by county, by multiplying the composite sum of cases in each county by 100,000, and dividing the product by each county's population ([CASES]*100000/[County Population]).

Twenty counties had 0 to 5 new cases of Hepatitis B infection reported, not sufficient to support a reliable rate estimate and were omitted. In all, a total of 1,627 cases of Hepatitis B infection (56 acute cases, and 1,571 chronic cases) were reported in Washington State during Calendar Year 2008.

Acquired Immunodeficiency Syndrome (Section 7b)

Counts of new Acquired Immunodeficiency Syndrome (AIDS) diagnoses and new cases of Human Immunodeficiency Virus (HIV) infection by county were obtained via Calendar Year 2008 data on epidemiologic trends and morbidity from the Infectious Disease and Reproductive Health Assessment Unit of the Washington State Department of Health (DOH).

In early 2008, the Washington DOH revised its statewide surveillance report and other routine data products so that more emphasis is given to new HIV diagnoses, which is considered to be the State's best routinely available measure of HIV risk. As such, AIDS diagnoses are no longer the preferred surveillance indicator in many states, including Washington.

Note that new HIV diagnosis and AIDS diagnosis events are not mutually exclusive. New HIV diagnoses represent people both with and without AIDS. In fact, more than a third of new HIV cases in Washington are either concurrently diagnosed with AIDS, or develop AIDS within 12 months of their initial HIV diagnosis.

Because of the long time period (8-10 years, on average) between HIV infection and the development of clinically apparent AIDS, combined with widespread availability of effective drug treatments which can either delay or reverse AIDS progression, it is difficult to determine what an AIDS diagnosis actually means. It could be an indication of someone who was recently infected with HIV and but who progressed to AIDS quickly, or it could represent someone who has been infected for some time and progressed to AIDS slowly, either for natural reasons or because at some point they initiated treatment (i.e., anti-retroviral therapy). Also, recent research has shown that HIV begins causing irreversible damage to the body soon after infection (Lancet 2009; 373: 181–83, Published Online August 4, 2008; DOI: 10.1016/S0140-6736(08)61006-5. Kaldor et al., 2009: *AIDS Case Reporting: do we still need it?*), which is why many experts (including the World Health Organization) are now advocating that HIV-positive patients not wait until they have developed AIDS in order to initiate treatment. This is also why the Washington DOH now prefers to describe all HIV-positive people as having HIV disease, regardless of their AIDS status.

Therefore, cases of new HIV diagnosis are distinctly counted for purposes of calculation.

These counts included cases of individuals newly diagnosed with HIV during Calendar Year 2008, by county. The incidence rate per 100,000 persons by county was calculated by multiplying the sum of CY 2008 HIV cases in each county by 100,000, and dividing the product by each county's population ([CASES]*100000/[County Population]).

Thirteen counties did not report any new cases of HIV. An additional 12 counties had fewer than 5 cases reported, not sufficient to support a reliable rate estimate and were omitted. In all, a total of 548 new cases of HIV were reported in Washington State during Calendar Year 2008.

Tuberculosis (Section 7c)

Data on Tuberculosis (TB) cases during Calendar Year 2008, and incidence rates per 100,000 persons by county were obtained from the Department of Health Office of Infectious Disease and Reproductive Health Assessment Unit; and from monthly DOH surveillance reports by county of epidemiologic trends and morbidity.

(http://www.doh.wa.gov/cfh/TB/default.htm)
(http://www.doh.wa.gov/EHSPHL/epitrends/08-epitrends/2008_trend.htm).

The incidence rate per 100,000 persons by county was calculated by multiplying the sum of CY 2008 TB cases in each county by 100,000, and dividing the product by each county's population ([CASES]*100000/[County Population]).

Sixteen counties did not report any cases of tuberculosis. Fourteen counties had fewer than 5 cases reported, not sufficient to support a reliable rate estimate and were omitted. In all, a total of 228 new cases of TB were reported in Washington State during Calendar Year 2008.

Form 5

Gender, Race and Ethnicity of Persons Needing Treatment Services

Two processes were used to estimate statewide counts of individuals in need of treatment services by age, gender, race and ethnicity.

The first process employed synthetic estimation, as conducted by the Washington State RDA. The basis for these estimates was constructed from the 2003 Washington State Needs Assessment and Household Survey (WANAHS II). The population matrix contains counts of adult persons ages 18 and over in demographic groups defined by age, gender, race/ethnicity, and poverty status. Population estimates were obtained from the 2000 U.S. Census, and adjusted to reflect population growth to Calendar Year 2008 using estimates from the 2008 Population Trends as developed by the Washington State Office of Financial Management (updated August 2009).

The second process was the development of a set of estimates for youth, by leveraging the National Survey on Drug Use and Health (NSDUH) in combination with FY 2008 alcohol/drug risk information for about 200,000 Medicaid youth ages 12-17, to create the necessary demographic detail that populates a matrix against which prevalence rates could be estimated.

To estimate treatment need among youth, RDA used the latest published Washington State specific alcohol/drug abuse/dependence measures from the NSDUH to estimate statewide treatment need among youth ages 12-17 (pooled 2006-07); and used administrative data indicators of alcohol/drug treatment need to allocate the NSDUH statewide estimate of need across race, ethnicity, and gender groups.

(http://www.oas.samhsa.gov/2k7State/AppB.htm#TabB-20)

Separate adjustment ratios were employed due to slight differences in race/ethnicity distribution of the Washington Department of Social and Health Services medical population, relative to the statewide population of youth aged 12-17. The treatment need rate among Native Hawaiians and other Pacific Islanders (NHOPI) was estimated using the WANAHS II current need for treatment prevalence rate for low-income adults, relative to the statewide average (13.8% for NHOPI relative to 13.6% statewide average for low-income adults).

Data on youth population were obtained from the Washington State Population Estimates for Public Health for Calendar Year 2008, as developed by the Washington State Department of Health, in conjunction with the Vista Partnership and Krupski Consulting.

The overall total and totals by gender, race and ethnicity are composite sums of the age groupings developed by the two aforedescribed processes (i.e., including persons ages 12-17, 18-24, 25-44, 45-64, and 65 and over).

Due to rounding, race and ethnicity numbers may not sum exactly to the statewide total.

County and statewide population estimates for adults and youth sum to estimates from the Calendar Year 2008 Population Trends as developed by the Washington State Office of Financial Management (updated

August 2009). The population estimates closely comport with the Washington State Population Estimates for Public Health for Calendar Year 2008.

Form 6 (formerly Form 11)

INTENDED USE PLAN

(Include ONLY Funds to be spent by the agency administering the block grant. Estimated data are acceptable on this form)

SOURCE OF FUNDS

	(24 Month Projections)					
Activity	**A.SAPT Block Grant FY 2011 Award**	**B.Medicaid (Federal, State and Local)**	**C.Other Federal Funds (e.g., Medicare, other public welfare)**	**D.State Funds**	**E.Local Funds (excluding local Medicaid)**	**F.Other**
Substance Abuse Prevention* and Treatment	$ 24,599,339	$ 51,420,000	$ 96,614,000	$ 169,158,000	$ 2,718,000	$
Primary Prevention	$ 8,744,576		$	$	$	$
Tuberculosis Services	$	$	$	$	$	$
HIV Early Intervention Services	$	$	$	$	$	$
Administration: (Excluding Program/Provider Lvl)	$ 1,754,943		$	$ 14,416,000	$	$
Column Total	**$35,098,858**	**$51,420,000**	**$96,614,000**	**$183,574,000**	**$2,718,000**	**$0**

***Prevention other than Primary Prevention**

Form 6ab (formerly Form 11ab)

Form 6a. Primary Prevention Planned Expenditures Checklist

Activity	Block Grant FY 2011	Other Federal	State Funds	Local Funds	Other
Information Dissemination	$ 174,892	$	$	$	$
Education	$ 3,410,385	$	$	$	$
Alternatives	$ 2,011,252	$	$	$	$
Problem Identification & Referral	$ 2,448,481	$	$	$	$
Community Based Process	$ 437,229	$	$	$	$
Environmental	$ 262,337	$	$	$	$
Other	$	$	$	$	$
Section 1926 - Tobacco	$	$	$	$	$
Column Total	**$8,744,576**	**$0**	**$0**	**$0**	**$0**

Form 6b. Primary Prevention Planned Expenditures Checklist

Activity	Block Grant FY 2011	Other Federal	State Funds	Local Funds	Other
Universal Direct	$	$	$	$	$
Universal Indirect	$	$	$	$	$
Selective	$	$	$	$	$
Indicated	$	$	$	$	$
Column Total	**$0**	**$0**	**$0**	**$0**	**$0**

Form 6c (formerly Form 11c)

Resource Development Planned Expenditure Checklist

Did your State plan to fund resource development activities with FY 2011 funds?

◉ Yes ○ No

Activity	Treatment	Prevention	Additional Combined	Total
Planning, Coordination and Needs Assessment	$ 1,083,000	$ 22,500	$	$ 1,105,500
Quality Assurance	$ 199,000	$ 50,000	$	$ 249,000
Training (post-employment)	$	$ 41,155	$	$ 41,155
Education (pre-employment)	$	$ 8,087,071	$	$ 8,087,071
Program Development	$	$ 451,250	$	$ 451,250
Research and Evaluation	$ 365,000	$	$	$ 365,000
Information Systems	$ 201,000	$ 199,180	$	$ 400,180
Column Total	**$1,848,000**	**$8,851,156**	**$0**	**$10,699,156**

Purchasing Services

This item requires completing two checklists.

Methods for Purchasing

There are many methods the State can use to purchase substance abuse services. Use the following checklist to describe how your State will purchase services with the FY 2011 block grant award. Indicate the proportion of funding that is expended through the applicable procurement mechanism.

☐ Competitive grants	Percent of Expense: %
☐ Competitive contracts	Percent of Expense: %
☐ Non-competitive grants	Percent of Expense: %
☑ Non-competitive contracts	Percent of Expense: 100 %
☐ Statutory or regulatory allocation to governmental agencies serving as umbrella agencies that purchase or directly operate services	Percent of Expense: %
☐ Other	Percent of Expense: %

(The total for the above categories should equal 100 percent.)

☐ According to county or regional priorities	Percent of Expense: %

Methods for Determining Prices

There are also alternative ways a State can decide how much it will pay for services. Use the following checklist to describe how your State pays for services. Complete any that apply. I n addressing a State's allocation of resources through various payment methods, a State may choose to report either the proportion of expenditures or proportion of clients served through these payment methods. Estimated proportions are acceptable.

☐ Line item program budget

Percent of Clients Served: %
Percent of Expenditures: %

☐ Price per slot

Percent of Clients Served: %
Percent of Expenditures: %

Rate: $	Type of slot:
Rate: $	Type of slot:
Rate: $	Type of slot:

☐ Price per unit of service

Percent of Clients Served: %
Percent of Expenditures: %

Unit:	Rate: $
Unit:	Rate: $
Unit:	Rate: $

☐ Per capita allocation (Formula:)

Percent of Clients Served: %
Percent of Expenditures: %

☑ Price per episode of care

Percent of Clients Served: %
Percent of Expenditures: 100 %

Rate: $	Diagnostic Group: Outpatient - See Footnote
Rate: $	Diagnostic Group: Residential - See Footnote
Rate: $	Diagnostic Group: Detoxification - See Footnote

Rates
Tuberculosis Test Intradermal $4.91
Group Youth $6.93
Group Adult $5.30
Individual w/wo Client $21.29
Expanded Assessment $195.46
Assessment $126.69
Intake Processing $14.72
Initial Screen $20.16
Cae Management $222.64
Sub Acute Detox $119.20
Acute Detox $163.20
Room/Board Detox $12.80
Opiate Subsitution Tx $14.07
Case Management - General $11.13
Adult Intensive Inpatient $90.18
Adult Long Term $53.52
Adult Recovery House $41.14
PPW Housing Support $13.79

Program Performance Monitoring

- [x] On-site inspections

  Frequency for treatment: EVERY TWO YEARS

  Frequency for prevention: ANNUALLY

- [x] Activity Reports

  Frequency for treatment: ANNUALLY

  Frequency for prevention: SEMI-ANNUALLY

- [x] Management Information System

- [x] Patient/participant data reporting system

  Frequency for treatment: MONTHLY

  Frequency for prevention: MONTHLY

- [x] Performance Contracts

- [ ] Cost reports

- [x] Independent Peer Review

- [x] Licensure standards - programs and facilities

  Frequency for treatment: OTHER Every Three Years

  Frequency for prevention: NOT APPLICABLE

- [x] Licensure standards - personnel

  Frequency for treatment: OTHER Every Three Years

  Frequency for prevention: NOT APPLICABLE

Other:

- [ ] Specify:

Form 7

State Priorities

	State Priorities
1	1. Develop a comprehensive statewide needs assessment.
2	2. Maintain a continuum of addictive disorder services to include prevention, intervention, treatment and recovery supports.
3	3. Reduce underage drinking.
4	4. Expand and improve a recovery-oriented system of care.
5	5. Integrate mental health and chemical dependency services into a comprehensive behavioral health system.
6	6. Develop the workforce.
7	7. Facilitate health care reform implementation with staff and providers.

Goal #1: Improving access to Prevention and Treatment Services

The State shall expend block grant funds to maintain a continuum of substance abuse prevention and treatment services that meet these needs for the services identified by the State. Describe the continuum of block grant-funded prevention (with the exception of primary prevention; see Goal # 2 below) and treatment services available in the State (See 42 U.S.C. §300x-21(b) and 45 C.F.R. §96.122(f)(g)).

Note: In addressing this narrative the State may want to discuss activities or initiatives related to: *Providing comprehensive services; Using funds to purchase specialty program(s); Developing/maintaining contracts with providers; Providing local appropriations; Conducting training and/or technical assistance; Developing needs assessment information; Convening advisory groups, work groups, councils, or boards; Providing informational forum(s); and/or Conducting provider audits.*

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

GOAL 1: Continuum of Services
FY 2011-2013 (Intended Use)

Even in the difficult budgetary climate of Washington State, DBHR has managed thus far to maintain a full continuum of prevention, intervention, treatment, and recovery support services.

Block Grant funds in FFY 2011-2013 funds will support primary prevention, patients in adult residential programs under the Alcoholism and Drug Addiction Treatment and Support Act (ADATSA, the state's chemical dependency support program for indigent person who are unable to work because of their addiction), housing support services, and outpatient treatment (including opiate substitution treatment) and ancillary services (i.e., transportation, childcare, interpreter services.) DBHR does not provide direct services. Funding for outpatient services will be contracted through counties and tribe, and is based on population and treatment need. There are 39 counties and 29 tribes located within six regions and managed by three regional administrators. Tribal programs provide services mostly to the tribal populations; however, they do have the option of serving non-tribal members as well. Each county has been responsible for submitting a strategic plan based on local needs, taking account of state-mandated and federal priorities. Tribes will be required to do the same for the 2011-2013 contracts.

In FFY 2011-2013, DBHR will continue to emphasize the use of evidence-based practices in primary prevention In FFY 2010, 69% of primary prevention programs were evidence-based. In addition, under DBHR's Prevention Redesign Initiative, funds will be directed to specific communities, which will be carefully monitored so that the impact on substance abuse incidence among youth can be measured.

Through its Parent-Child Assistance Program, DBHR will offer paraprofessional advocacy and intervention services for substance-abusing women with young children. Advocates will help women identify and prioritize realistic goals and steps to meet them, make referrals to chemical dependency treatment and recovery services where needed, and help individuals access local resources.

<u>Expand and improve a recovery-oriented system of care.</u>

DBHR recognizes that, in addition, to treatment, recovery support services are important adjuncts in helping ensure individuals can move toward health lifestyles and return to active, productive lives in their families and communities. Critical to the delivery of these services is embedding them with a recovery-oriented system of care in which clients can identify and prioritize realistic goals and steps to meet them, and select those services which they believe can aid them on the path to recovery.

Washington State is the national leader in number of Oxford Houses, with 222 houses and more than 1,900 beds. These resident-run, cooperative houses provide stable, post-treatment housing to individuals who participate in recovery programs. DBHR expects to assist in the continued expansion of Oxford Houses in FFY 2011-2013. More detail can be found in Goal 7.

Through DBHR's Safe Babies Safe Moms program, it expected that 250 substance-abusing pregnant, postpartum, and parenting women and their children from birth-to-three will receive treatment and recovery support services at sites in three counties. Following treatment, housing support and recovery services will be provided for women with their children. Transitional housing will be provided for up to 18 months.

<u>Develop the workforce.</u>

DBHR expects to maintain and, within available funds, expand its Community Prevention Training (CPT) initiative that provides financial support to county governments to increase their capacity to utilize

evidence-based prevention practices (EBPs). Substance Abuse Prevention Specialists Training will instruct local local providers how to best plan for prevention services to achieve optimum outcomes, including both risk and protective factors and prevalence measures.

DBHR plans to provide training and continuing education opportunities to more than 1,750 substance abuse professionals each year in FFY 2011-2013. These opportunities, provided through statewide conferences and local and regional trainings, utilize a coordinated approach to address and promote workforce development and provide effective and high-quality clinical training. Trainings are designed to meet either specific needs as identified through counties strategic plans or are linked to statewide priorities or needs assessments. It is expected there will be at least three statewide conferences each year: The Prevention Summit; Co-Occurring Disorders and Treatment Conference: and the "Saying It Out Loud" conference (which addresses the specific needs of sexual minorities.) More detail can be found in Goal 11.

Given the requirements of health care reform, workforce efforts will address the need for coordination/collaboration between the treatment field and primary care organizations.

Spending Plan

DBHR expects to use FFY 2011-2013 Block Grant allocations as follows:

- 25% will be utilized for prevention services
- 71% will be utilized for treatment and recovery support services
- 4% will be utilized for training, workforce development, and administration

Of total Block Grant funds, it is expected that:

- 48% will be allocated to counties for prevention and treatment services
- 8% will be allocated to the tribes for prevention and treatment services
- 40% will be allocated to residential treatment and recovery support services. (More than 90% of this allocation will be for adult clients)

Washington State is in a significant economic downturn, with several changes to the state budget. Block Grant funds will play a critical role in maintaining the continuum of substance abuse-related services, especially until the availability of state resources returns to be more stable and sustainable levels.

Goal 1- Continuum of Services
FY2008 (Compliance)

State Law RCW 70.96A identifies the Division of Behavioral Health and Recovery (DBHR) as the "single state agency" for planning and delivery of substance abuse treatment and prevention services. All public substance abuse services funded by state or federal funds were either managed by DBHR, or operated in coordination with DBHR (for example, services provided by the Department of Health, the Department of Licensing, the Department of Corrections, and the Office of the Superintendent of Public Instruction).

In FFY 2008, DBHR did not provide direct prevention or treatment services, but rather, provided contracted for services with county governments, Native American tribes, and non-profit service providers. The largest portions of available federal and state funds were contracted through county and tribal governments. For the SFY 2007-2009 Biennium, DBHR designed a plan for program development; and prevention and treatment service strategies.

County governments and tribes were awarded prevention and treatment funds on the basis of a formula established by DBHR in coordination with these governmental units. Counties conducted a needs assessment for prevention and treatment needs, based on available funding, and submitted a plan to DBHR. Contracts for community-based prevention and treatment services included work statements specifying the activities provided under the contracts. DBHR regional prevention and treatment managers monitored all contracts to ensure work met contractual requirements.

DBHR performed seven major program management functions:

- Program policy and planning
- Program compliance
- Certification and evaluation of providers
- Fiscal and contract management
- Training and technical assistance
- Management Information Systems (MIS)
- Comprehensive program research and outcome studies

Activity 1-1 (Compliance)
SERVICE DELIVERY MECHANISMS

Alcohol/Drug Detoxification – In FFY 2008, there were 13,729 adult admissions to detoxification services, the highest number in more than a decade. Detoxification for alcohol accounted for 61.2 percent of all detoxification admissions. There was a significant increase in the percentage of individuals entering DBHR-funded treatment within 30 days of discharge from detoxification services, rising from 30.2 percent in FFY 2004, to 34.0 percent in FFY 2008. There were 393 youth admissions to detoxification services in FFY 2008, 40.0 percent of which were for marijuana.

Outpatient Treatment – In FFY 2008, there were 29,419 adult admissions to publicly funded outpatient/intensive outpatient treatment, representing 64.6 percent of all adult admission (excluding detoxification). This represents a 7.4 percent increase over FFY 2007, and a 34.2 percent increase since FFY 2004. Some 49.1 percent completed outpatient treatment, a significant improvement over 44.2 percent in FFY 2004.

Opiate Substitution Treatment – In FFY 2008, there were 2,253 admissions to publicly funded opiate substitution treatment. During that same year, 5,421 received publicly funded opiate substitution

treatment. Of those served, 88.9 percent remained in treatment for at least six months, 80.1 percent remained in treatment for at least one year. Some 68.8 percent of those admitted in FFY 2008 reported heroin as their primary substance of abuse; 31.2 percent reported prescription-type opiates.

Intensive Inpatient Treatment – In FFY 2008, there were 10,393 adult admissions to publicly funded intensive inpatient treatment, representing a 3.9 percent increase over FFY 2007, and a 68.0 percent increase over FFY 2004. Some 79.1 percent completed treatment.

Recovery House – In FFY 2008, there were 847 adult admissions to publicly funded recovery house, representing a 19.6 percent increase over FFY 2007.

Long-Term Residential Treatment – In FFY 2008, there were 2,662 adult admissions to publicly funded long-term residential treatment, representing a 2.6 percent increase over FFY 2007, and a 25.4 percent increase over FFY 2004.

Youth Residential Treatment – In FFY 2008, there were 1,417 youth admissions to residential treatment, representing an 8.7 percent increase over FFY 2004. Some 74.8 percent of youth admitted completed treatment.

Youth Outpatient Treatment - In FFY 2008, there were 5,098 youth admissions to publicly funded outpatient/intensive outpatient treatment, a 7.7 percent increase over FFY 2007. Some 49.3 percent of youth admitted completed treatment.

In virtually every area, the number of individuals admitted to publicly funded treatment increased in FFY 2008, representing Washington State's sustained and increasing commitment to serving the needs of individuals with chemical dependency. At the same time, length-of-stay in treatment and treatment completion has also been rising, which represents an enhanced partnership between DBHR, counties, tribes, and providers to ensure the quality of care.

Special efforts were made to provide treatment services to: pregnant and parenting women, injection drug users families with children, recipients of child welfare services and child protective services' clients, adolescents, individuals referred by the criminal justice system ethnic minorities, persons with HIV/AIDS, and individuals with co-occurring mental health and substance abuse disorders. In FFY 2008:

- 1,952 pregnant and parenting women received treatment. Of these, 34.6 percent had a co-occurring mental health disorder, and 22.3 percent received mental health treatment in the year prior to admission. Some 57.5 percent had a past history of domestic violence.
- Some 54.2 of youth admitted to chemical dependency treatment in FFY 2008 reported an arrest in the year prior to treatment.
- 3,693 individuals received treatment through the state-funded Criminal Justice Treatment Account.
- Racial and ethnic minorities represented 34 percent of adult admissions to publicly funded admissions to treatment, and 42 percent of youth admissions.
- Approximately 16 percent of adult individuals admitted to treatment in FFY 2008 were homeless at time of admission.
- Some 30.1 percent of adults admitted to treatment in FFY 2008 had a co-occurring mental health disorder. Beginning in 2007, chemical dependency and mental health treatment providers began using a common co-occurring disorders screening and assessment process.
- Some 1,941 military veterans were admitted to treatment in FFY 2008.

Activity 1-2 (Compliance)
PREVENTION AND PUBLIC EDUCATION ACTIVITIES

DBHR supported youth prevention activities to reduce the incident of substance abuse among Washington's youth. These programs utilized an evidence-based risk-and-protective-factor framework. Communities and schools pursued multiple strategies selected from science-based approaches to meet the prevention needs of their youth populations. Service delivery was contracted through counties (sub-state planning areas), tribes, schools, and educational service districts.

Programs included:

- School-based K-12 substance abuse curricula
- College- and university-based programs
- Education and support programs with children of substance users
- Peer support programs
- School staff intervention team programs
- Student assistance programs
- Community-based parenting training
- Community prevention taskforce development
- School and community taskforce training
- Development and implementation of early childhood taskforce models
- Mentoring

Children transitioning between elementary and middle school, and between middle school and high school, parents of young children, children of chemically dependent or substance-abusing parents, school drop-outs, and children exposed to illegal drug use and/or alcohol were specially targeted.

In contracts with county prevention providers, providers were required to use evidence-based best or promising practices for at least 50% of programming. In FFY 2008, 69% of programs represented best or promising practices. Among FFY 2008 prevention program participants, 22, 969 individuals were in programs representing best practices, 3,230 in programs using promising approaches, and 2,559 in programs using innovative practices. Through its Performance-Based Prevention System, DBHR tracked both decreased use and increased abstinence from alcohol and drug use among prevention program participants. Based on studies conducted by the Washington State Institute for Public Policy, it is estimated that, over the lifetimes. For participating youth, in SFY 2009, Washington State prevention programs saved $19.1 million in likely costs (criminal justice costs, unemployment, and medical costs).[*]

DBHR funded statewide services (sometimes with the aid of federal grants beyond the SAPT blockgrant) by way of interagency agreements and partnerships with state agencies and non-profit organizations. These included:

- School-Based Prevention and Intervention Services Program
- Healthy Youth Survey
- Reducing Underage Drinking Initiative
- Reducing Access to Tobacco Products (Synar Regulation)
- College Coalition for Substance Abuse Prevention
- Children's Transition Initiative
- Alcohol/Drug Clearinghouse

[*] Aos, S, et al. *Benefits and Costs of Prevention and Early Intervention Programs for Youth.* Olympia, WA: Washington State Institute for Public Policy (WSIPP), 2004. Calculated by multiplying the number of participants enrolled in each program by the cost savings per participant listed in WSIPP report.

- Exemplary Substance Abuse Prevention Awards
- Public Education and Communications Program
- Washington State Prevention Summit
- Drug-Free Communities
- State Prevention Framework-State Incentive Grant

In addition, DBHR promoted prevention efforts aimed at populations other than youth. These included coordinating with higher education and campus-based groups to organize model programs pursuing drug-free campuses. DBHR also supported environmental prevention strategies, which included pharmaceutical drug take-back programs and prescription monitoring efforts. It is estimated that, in FFY 2008, some 390,162 individuals were reached through single services, including media campaigns and public awareness efforts.

Activity 1-3 (Compliance)
STRATEGIC PRIORITIES

From the latest iteration of its strategic plan for 2009-2013, DBHR pursued five strategic priorities:

§ Reaffirm our commitment to evidence-based, targeted substance abuse prevention, and continue to implement efforts to combat underage drinking;
§ Expand the range and location of intervention services available to non-chemically dependent, substance-abusing youth and adults;
§ Assure delivery of a full range of high quality chemical dependency treatment services to adults and youth who are eligible and in need of them;
§ Promote the wider availability of aftercare and support services to assist individuals in their recovery from alcohol and other drug addiction;
§ Ensure an adequate, diverse, and competent workforce capable of meeting the substance use-related needs of Washington residents.

In keeping with these priorities, DBHR examinef its statutory authority, its position within the larger Department of Social and Health Services, its relationships within its partners in the prevention and treatment communities, and its ongoing commitment to client health and safety, self-sufficiency, public safety, prevention, equal access and opportunity, and public stewardship

Goal 1 – Continuum of Services
FY 2010 (Progress)

The Division of Behavioral Health and Recovery (DBHR) develops and conducts a comprehensive program of alcohol and other drug abuse prevention, intervention, treatment, and recovery support services for residents of the state of Washington. Our mission is to promote strategies that support healthy lifestyles by preventing the misuse of alcohol, tobacco, and other drugs, and support recovery from the disease of chemical dependency. To succeed in its mission, DBHR is dedicated to building collaborative partnerships with communities, tribes, service providers, schools, colleges and universities, the criminal justice system, and other agencies within the private sector and within local, state, and federal governments. DBHR is committed to ensuring services are provided to individuals and communities in ways that are culturally relevant, and honor the diversity of Washington State. Monitoring the continuum of services in Washington State assists us in meeting our mission.

For FFY 2010, progress in accomplishing our mission is supported by:

- Certifying and providing technical assistance to providers of chemical dependency (CD) treatment services.
- Contracting with 39 counties and 29 tribes (which, in turn, contract with outpatient treatment providers), and 46 youth and adult intensive inpatient, long-term residential, and PPW (pregnant and postpartum women) treatment organizations to provide CD treatment services to persons who are dependent or harmfully affected by substance use.
- Coordinating a comprehensive program of drug prevention and early intervention.

Activity 1-1 (Progress)
SERVICE DELIVERY MECHANISMS (Treatment data for FFY 2010 are for 10 months, October 2009-July 2010. Comparisons are for similar 10-month periods.)

DBHR does not provide direct client treatment services using state staff. All outpatient services for indigent and low-income patients are through contracts with each of the state's counties and tribes. Counties are designated sub-state planning areas. Residential service contracts are managed by our program managers based in the regional offices.

Three Regional Administrators, manage both the county and tribal contracts. We continue to hold contracts directly with residential service providers. Our certification staff monitors treatment providers to ensure compliance with rules and regulations.

Alcohol/Drug Detoxification – In FFY 2010, there were 10,396 adult admissions to detoxification. Detoxification for alcohol accounted for 49.4 percent of all detoxification admissions. Between July 2008 and June 2010, 30.3 percent of individuals discharged from detoxification entered DBHR-funded treatment within 30 days of discharge. There were 437 youth admissions to detoxification services in FFY 2010, 44.3 percent of which were for marijuana.

Outpatient Treatment – In FFY 2010, there were 23,826 adult admissions to publicly funded outpatient/intensive outpatient treatment, representing 67.2 percent of all adult admission (excluding detoxification). This represents a 3.1 percent increase over FFY 2007, and a 30.9 percent increase since FFY 2004. Some 53.5 percent completed outpatient treatment, a significant improvement over 44.7 percent in FFY 2004.

Opiate Substitution Treatment – In FFY 2010, there were 1,561 admissions to publicly funded opiate substitution treatment. During that same year, 5,708 received publicly funded opiate substitution

treatment. Of those served, 82.9 percent remained in treatment for at least six months, 67.9 percent remained in treatment for at least one year. Some 66.3percent of those admitted in FFY 2010 reported heroin as their primary substance of abuse; 33.7 percent reported prescription-type opiates.

Intensive Inpatient Treatment – In FFY 2010, there were 10,393 adult admissions to publicly funded intensive inpatient treatment. Some 79.0 percent completed treatment.

Recovery House – In FFY 2010, there were 491 adult admissions to publicly funded recovery house.

Long-Term Residential Treatment – In FFY 2010, there were 1,873 adult admissions to publicly funded long-term residential treatment. Some 74.6% completed treatment.

Youth Residential Treatment – In FFY 2010, there were 1,018 youth admissions to residential treatment. Some 75.7 percent of youth admitted completed treatment.

Youth Outpatient Treatment - In FFY 2010, there were 4,465 youth admissions to publicly funded outpatient/intensive outpatient treatment, a 10.8 percent increase over FFY 2007. Some 58.3 percent of youth admitted completed treatment.

While Washington State has experienced state budget difficulties, in most areas the number of individuals admitted to publicly funded treatment increased in FFY 2010, which represents Washington State's sustained commitment to serving the needs of chemically dependent individuals. At the same time, length-of-stay in treatment and treatment completion has also been rising, which represents an enhanced partnership between DBHR, counties, tribes, and providers to ensure the quality of care.

Special efforts continue to be made to provide treatment services to: pregnant and parenting women, injection drug users families with children, recipients of child welfare and child protective services' clients, adolescents, individuals referred by the criminal justice system, ethnic minorities, , , persons with HIV/AIDS, and individuals with co-occurring mental health and substance abuse disorders. In FFY 2010:

- In FFY 2010, 1,807 pregnant and parenting women received treatment. Of these, 35.3 percent had a co-occurring mental health disorder, and 24.7% received mental health treatment in the year prior to admission. More than half (52.9 percent) had a past history of being victims of domestic violence.
- 2,385 individuals received treatment in FFY 2010 through the state-funded Criminal Justice Treatment Account.
- More than half (54.2 percent) of youth admitted to chemical dependency treatment in FFY 2010 reported an arrest in the year prior to admission.
- Racial and ethnic minorities represented 35 percent of adult admissions to publicly funded admissions to treatment, and 46 percent of youth admissions.
- Approximately 16 percent of adult individuals admitted to treatment in FFY 2010 were homeless at time of admission.
- Some 34.2 percent of adults admitted to treatment in FFY 2010 had a co-occurring mental health disorder. Beginning in 2007, chemical dependency and mental health treatment providers began using a common co-occurring disorders screening and assessment process.
- Some 1,249 military veterans were admitted to treatment.

Activity 1-2 (Progress)
PREVENTION AND PUBLIC EDUCATION ACTIVITIES (Prevention data for FFY 2010 are for 10 months, October 2009-Augsut 2010.)

Through contracts with the counties (sub-state planning areas), tribes, and Educational Service Districts, we support youth prevention service activities designed to reduce the incidence of substance abuse among Washington's youth. These activities are designed to reduce risk factors and enhance protective factors associated with adolescent substance abuse and misuse.

Community and statewide prevention efforts for adolescents and younger children are based on estimates of risk using factors shown to predict future substance abuse. Strategies are selected to reduce risk, or increase known protective factors among at-risk youth.

In contracts with county prevention providers, providers are required to use evidence-based best or promising practices for at least 50% of programming. In FFY 2010,18,275 individuals received recurring services. Through its Performance-Based Prevention System, we tracked both decreased use and increased abstinence from alcohol and drug use among prevention program participants. Based on studies conducted by the Washington State Institute for Public Policy, it is estimated that, over the lifetimes of participating youth in SFY 2010, Washington State prevention programs saved $26.0 million.[*]

We funded statewide services (sometimes with the aid of federal grants beyond the SAPT block grant) by way of interagency agreements and partnerships with state agencies and non-profit organizations. These included:

- School-Based Prevention and Intervention Services Program
- Healthy Youth Survey
- Reducing Underage Drinking Initiative
- Reducing Access to Tobacco Products (Synar Regulation)
- College Coalition for Substance Abuse Prevention
- Children's Transition Initiative
- Alcohol/Drug Clearinghouse
- Exemplary Substance Abuse Prevention Awards
- Public Education and Communications Program
- Washington State Prevention Summit
- Drug-Free Communities
- State Prevention Framework-State Incentive Grant

DBHR also supports environmental prevention strategies, which include pharmaceutical drug take-back programs and prescription monitoring efforts. It is estimated that, in FFY 2010, some 876,252 individuals were reached through single services, including media campaigns and public awareness efforts.

In addition, we promote prevention efforts aimed at populations other than youth. This includes coordinating with higher education and campus-based groups to organize model programs pursuing drug-free campuses. Some 23 public and private, two- and four-year colleges participate in the statewide College Coalition Against Substance Abuse. Of these, 17 member colleges implemented Electronic Check-up To Go, an online self-assessment of drinking behavior that frequently results in self-referral for additional support and services. Seven member colleges are implementing Brief Alcohol Screening and Intervention of College Students **(**BASICS) – a best practice, motivational interviewing-based aimed at students who drink alcohol heavily and have experienced or are at risk for experiencing alcohol-related problems such as poor class attendance, missed assignments accidents, sexual assault, and violence.

[*] Aos, S, et al. *Benefits and Costs of Prevention and Early Intervention Programs for Youth.* Olympia, WA: Washington State Institute for Public Policy (WSIPP), 2004. Calculated by multiplying the number of participants enrolled in each program by the cost savings per participant listed in WSIPP report.

Activity 1-3 (Progress)
STRATEGIC PRIORTIES

DBHR is examining both challenges and opportunities in meeting the priorities as identified in the 2009 - 2013 Strategic Plan to ensure we effectively achieve the mission: to promote strategies that support healthy lifestyles by preventing the misuse of alcohol, tobacco, and other drugs, and support recovery from the disease of chemical dependency:

In addition, DBHR is examining its statutory authority, its place within the Department of Social and Health Services, its relationships with its partners in the prevention and treatment communities, its delivery of services to those with co-occurring substance abuse and mental health disorders, and its ongoing commitment to client health and safety, self-sufficiency, public safety, prevention, equal access and opportunity, and public stewardship.

Goal #2: Providing Primary Prevention services

An agreement to spend not less than 20 percent of the SAPT Block Grant on a broad array of primary prevention strategies directed **at individuals not identified to be in need of treatment**. Comprehensive primary prevention programs should include activities and services provided in a variety of settings for both the general population, and targeted sub-groups who are at high risk for substance abuse.

Specify the activities proposed for each of the six strategies or by the Institute of Medicine Model of Universal, Selective, or Indicated as defined below: (See 42 U.S.C.§300x-22(a)(1) and 45 C.F.R. §96.124(b)(1)).

Primary Prevention: Six (6) Strategies

• **Information Dissemination** – This strategy 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 source to the audience, with limited contact between the two.

• **Education** –This strategy 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 abilities. There is more interaction between facilitators and participants than in the information strategy.

• **Alternatives** –This strategy provides participation in activities that exclude alcohol and other drugs. The purpose is to meet the needs filled by alcohol and other drugs with healthy activities, and to discourage the use of alcohol and drugs through these activities.

• **Problem Identification and Referral** –This strategy aims at identification of those who have indulged in illegal/age-inappropriate use of tobacco or alcohol and those individuals who have indulged in the first use of illicit drugs in order to assess if their behavior can be reversed through education. It should be noted however, that this strategy does not include any activity designed to determine if a person is in need of treatment.

• **Community-based Process** –This strategy 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** –This strategy establishes or changes written and unwritten community standards, codes, and attitudes, thereby influencing alcohol and other drug use by the general population.

Institute of Medicine Classification: Universal, Selective and Indicated:

o ***Universal:*** Activities targeted to the general public or a whole population group that has not been identified on the basis of individual risk.
o ***Universal Direct. Row 1*** —Interventions directly serve an identifiable group of participants but who have not been identified on the basis of individual risk (e.g., school curriculum, after school program, parenting class). This also could include interventions involving interpersonal and ongoing/repeated contact (e.g., coalitions)

o ***Universal Indirect. Row 2***—Interventions support population-based programs and environmental strategies (e.g., establishing ATOD policies, modifying ATOD advertising practices). This also could include interventions involving programs and policies implemented by coalitions.
o ***Selective:*** Activities targeted to individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average.
o ***Indicated:*** Activities targeted to individuals in high-risk environments, identified as having minimal but detectable signs or symptoms foreshadowing disorder or having biological markers indicating predisposition for disorder but not yet meeting diagnostic levels. *(Adapted from The Institute of Medicine Model of Prevention)*

• *Note:* In addressing this narrative the State may want to discuss activities or initiatives related to: *Disseminating information to stakeholders; Providing education; Providing training/TA Discussing environmental strategies; Identifying problems and/or making referrals; Providing alternative activities; Developing and/or maintaining sub-state contracts; Developing and/or disseminating promotional materials; Holding community forums/coalitions; Using or maintaining a management information system (MIS); Activities with advisory council, collaboration with State Incentive Grant (SIG) project; Delivering presentations; Data collection and/or analysis; Toll-free help/phone line provision; Procuring prevention services through competitive Request for Proposals (RFPs); Site monitoring visits*

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

Goal 2 – Primary Prevention
FY 2011 - 2013 (Intended Use):

Public Information and Education

The goal for FFY 2011 – 2013 is to continue to implement prevention communication and education strategies that support policies and practices that reduce underage drinking and other drug use in Washington State.

Through a contract with the Alcohol and Drug Clearinghouse, (Clearinghouse) an information and resource center will continue to provide accurate and current drug education and prevention materials statewide. Reduced funding for this program may result in operating with fewer staff and for fewer hours, which could result in a decrease of services. However, the following services will be required to continue:

- Information and Resources: A local and statewide toll-free phone number will continue to be maintained for people requesting resources, including a system to receive requests by telephone from the hearing-impaired community. Staff will be expected to be available to respond to requests during the hours of 10:00 a.m. to 3:00 p.m., Monday through Friday, and to fill orders within 10 working days from the date of request.

- Print Materials: An inventory of brochures, posters and other items will continue to be available, when requested, for traditionally underserved and high-risk populations. All print materials will be available in English, Chinese, Japanese, Korean, Cambodian, Spanish, Russian, and Vietnamese.

- Video Library: A library of more than 200 videotapes on drug prevention related topics will be maintained and made available for loan to individuals and organizations throughout Washington State, as well as a video catalog that includes titles, descriptions, year produced, and intended audiences. Videos will be available in languages other than English and in American Sign Language. Each year (2011-2013) four new videotapes will be added to the library.

- Outreach: There will be continued outreach throughout Washington State at community meetings, conferences, and workshops to share resources and information. The contractor will continue to find information-sharing opportunities that address the needs of at-risk and underserved populations.

- Radar Network Center: The center will serve as Washington State's Regional Alcohol and Drug Awareness Resource (RADAR) Network Center, in accordance with RADAR guidelines.

- National Clearinghouse for Alcohol and Drug Information. The Contractor will continue to provide free access to RADAR Network materials, electronic communications, and technical assistance to Associate Center members.

- Electronic Resources: A website will continue to provide the public access to resources and information available from the Clearinghouse on drug abuse prevention and treatment.

Support for a multi-media campaign of prevention messaging through our alliance with the Partnership for a Drug Free America will continue. Media partners in Seattle and Spokane are expected to continue donating airtime.

In addition, the Clearinghouse will continue to publish and electronically distribute a statewide substance abuse newsletter entitled "prevention e-briefs" to communicate federal, state, and county prevention practices and initiatives, principles, and activities/campaigns. Prevention professionals, community members, school personnel, parents, students, and other individuals interested in substance abuse prevention will be encouraged to sign up for the newsletter. We plan to maintain a minimum of 1,000 individuals on the list serve and produce at least one prevention electronic bulletin per month.

The annual Prevention Summit will provide effective and efficient training that ensures that quality prevention services will be delivered in our state. We will continue to build on our foundation of success in Washington State by ensuring new information is available for youth and adults, new in the field or highly experienced, and from diverse backgrounds. The Prevention Summit will provide enriching and culturally competent training as well as networking opportunities for youth, volunteers and professionals working toward prevention of substance abuse, violence and other destructive behaviors and the promotion of mental health.

Collaboration with the College Coalition for Substance Abuse Prevention will continue. Through this collaboration ongoing opportunities for professional growth will be provided by addressing issues related to:

- prescription drugs
- mental health issues and substance use
- marijuana
- motivational interviewing
- services for mandated/sanctioned students
- issues related to veterans
- BASICS (Brief Alcohol Screening and Intervention for College Students- an evidence-based practice), and
- evaluation of prevention/wellness efforts

In addition, professional opportunities for 2-year colleges will cover:

- how community college prevention can connect, or be an extension, to 4-year colleges for transfer students
- topics specific to community college settings or working with students in transition from community colleges to universities

This coming school year, a minimum of seventeen higher education schools will be using Electronic Check-up to Go, an online alcohol intervention and social-norming program.

The Prevention Summit will be held early fall and will begin on a Thursday evening and continues to early afternoon on Saturday. The Summit will include many educational opportunities, for example:

- A two-day summit comprised of a youth leadership conference and an adult professional conference,
- Six keynote addresses and over 40 workshop presentations,
- Team building youth activities (ropes course, dance, crafts, and YMCA games),
- Evening activities such as, Native American storytelling, graphic recording and facilitating techniques, cultural dancing clinics and social-conscience film discussions,
- Professional networking opportunities,
- Awards Luncheon, and
- Youth Service Learning Projects.

The objectives for the Summit are:

- To understand and feel a part of the State Prevention "Big Picture,"
- To have an exceptional learning experience,
- To have people connect with new and past partners,
- For youth to be integral in planning and have a genuine opportunity for skill development, and
- To provide a culturally competent training opportunity and experience for participants.

We plan to explore additional funding opportunities that will allow us to add a mental health track and youth teams to the Summit. This will capitalize on the established training venue while also meeting the needs to fulfill the new direction of the federal and state government to address these shared community concerns: This new track could include training on: mental health and substance abuse prevention, prevention of depression, anxiety and suicide, and promotion of mental health.

Our support and collaboration with the "Washington State Mentoring Partnership" to implement evidenced-based mentoring strategies statewide will continue. As such, each provider will be responsible to provide program and outcome data through the prevention information system. Mentoring services will be monitored monthly with reporting on the following items.

- Unduplicated count of mentor-mentee matches
- Count of services attended
- Use of required survey instruments

Alternative activities will be offered through contracts with 39 counties and 29 tribes. Contractors will be required to report these activities monthly in the prevention MIS. Service levels for FFY11-13 will be measured against service numbers reported for FFY10:

- At least 62 programs will be offered
- At least 1,893 (unduplicated) participants attending at least one recurring service
- At least 41,493 (duplicated) participants attending at least one single event service

Problem and identification and referral services will be provided in schools through the Office of the Superintendent of Public Instruction (OSPI) Prevention and Intervention Specialists program. Service levels for FFY11-13 will be measured against service numbers reported for FFY10:

- In addition to OSPI at least 5 Counties and 1 Tribe Count will offer services.
- At least 13,248 (unduplicated) participants attending at least one recurring service
- At least 7,693 (duplicated) participants attending at least one single event service

We will continue to support "Community-based coordination" through contracts with 39 counties and 29 tribes. Contractors will be required to report these activities monthly in the prevention MIS. Service levels for FFY11-13 will be measured against service numbers reported for FFY10:

- At least 39 programs offered
- At least 1,521 (unduplicated) participants attending at least one recurring service
- At least 10,529 (duplicated) participants attending at least one single event service

DBHR will expand technical assistance and training to providers on evidence-based environmental prevention strategies, including promoting alcohol, tobacco, and other drug (ATOD) policies in schools and monitoring/changing advertising at the local level. Service levels for FFY11-13 will be measured against service numbers reported for FFY10:

- Programs will be offered in at least 1 county and 2 tribes.
- At least 819 (unduplicated) participants attending at least one recurring service

- At least 980 (duplicated) participants attending at least one single event service

DBHR contract managers review monthly service reports on administrative and outcome data entered into the Performance Based Prevention System for prevention services contracted through 39 counties, 29 tribes, and the Alcohol and Drug Clearinghouse. Additionally, annual onsite reviews are conducted by the contract manager. The College Coalition for Substance Abuse Prevention provides semiannual reports to the DBHR contract manager. The annual Prevention Summit uses registration data; youth projects completed; and participant, presenter, volunteer, sponsor, exhibitor and committee evaluations administered at conference and 4 months following to review program effectiveness. Prevention Summit information is reviewed by the contract managers and the interagency planning committee.

Goal 2 - FFY 2008: (compliance)

2-1.1
The Clearinghouse maintained an information and resource center that provided accurate and current drug education and prevention materials statewide. Materials and information was made accessible to all of Washington State's population, including non-English speaking individuals and people with disabilities. The following services were provided,:

- Information and Resources**:** A local and statewide toll-free phone number was maintained for people requesting resources, including a system to receive requests by telephone from the hearing-impaired community. Staff were available to respond to requests during the hours of 8:00 a.m. to 5:00 p.m., Monday through Friday. Requests for information were responded to within seven working days.
- Print Material**s:** An inventory of brochures, posters and other items were maintained and available when requested for traditionally underserved and high-risk populations. Written m materials were made available in English, Chinese, Japanese, Korean, Cambodian, Spanish, Russian, and Vietnames**e.**
- Video Library: A library of at least 200 videotapes on drug prevention related topics was made available for loaning to individuals and organizations throughout Washington State. Videos in languages other than English and American Sign Language were available. Four new videotapes were added to the video catalog
- Outreach: Staff was trained and was available to present resources and information throughout Washington State at community meetings, conferences, and workshops and sought information-sharing opportunities that addressed the needs of at-risk and underserved populations. Thirty outreach presentations were provided, with at least 6 presentations in Eastern Washington. Audiences included social service organizations, schools, and workplaces. Local volunteers, when possible, staffed resource tables and provided materials at 100 events during the contract period.
- Radar Network Center**:** Regional Alcohol and Drug Awareness Resource (RADAR) Network coordinated local networks of RADAR Associate Centers in Washington State. Free access to RADAR Network materials, electronic communications, and technical assistance was made available to Associate Center members.
- Electronic Resources: An internet website was maintained for public access to drug abuse prevention and treatment resources and information at the clearinghouse and in Washington State.

2-1.2 DBHR and key stakeholders from state and local agencies collaborated on speakers, presenters and activities for the 2008 Prevention Summit. We contracted with the University of Nevada Reno, Center for the Application of Substance Abuse Technologies to provide logistical coordination. The Prevention Summit included an adult and a youth track, each with a variety of presentations from national keynote speakers to local exemplary programs; learning and networking activities; and service projects.

The 2008 Prevention Summit was a success. Approximately 700 adults and youth attended the conference. At the Planning Committee Debriefing Meeting the goals and objectives and the results were reviewed, and it was determined that we met our intended impacts. Follow up feedback, coupled with a survey report, indicated that participants agreed the conference was successful. We are very proud of our accomplishments during this year. Please see attached report for details of the 2008 Prevention Summit.

2-1.3
DBHR supported and disseminated multi-media prevention messaging through its alliance with the Partnership for a Drug Free America. Media partners in Seattle and Spokane broadcasted new prevention messages and donated $113,000 in airtime.

2-1.4
The Alcohol/Drug Information Clearinghouse (our contractor) planned, developed, and distributed a statewide electronic bulletin for communicating federal, state, and county prevention practices and initiatives, principles, and activities/campaigns to individuals and organizations in all Washington counties and 29 federally recognized Tribes involved in prevention services. A list serve of 1,000 individuals was maintained. One prevention electronic bulletin per month was produced and published. Other prevention-related list serves were incorporated as they become available. Weekly e-briefs newsletters were distributed to 1,500 subscribers.

2-1.5
County contractors chose information dissemination as a strategy to provide knowledge and increase 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. Disseminated information also provided knowledge and increased awareness of available prevention and treatment services. There were 106,723 strategies implemented in FFY2008, which is an increase from the FFY2007 number of 104,390.

2-2.1
The University of Washington completed all aspects of this contract (College Coalition) including professional development sessions at statewide meetings and conference calls, to include:

- Evaluating Environmental Interventions to Reduce High-Risk Drinking. Robert Saltz, PhD, May 2, 2008
- Common Sense Assessment in Student Affairs: Fundamentals and Fun! Patricia Fabiano, PhD. , May 2, 2008.
- Are Social Norms the Best Predictors of Outcomes among Heavy-Drinking College Students? Clayton Neighbors, Ph.D, October 26, 2007
- The Network Addressing Collegiate Alcohol & Other Drug Issues, Patricia Ketchum, Ph.D., October 26, 2007

2-2.2
Services were provided statewide by 35 Counties and 18 Tribes by 208 programs with a focus on education. There were 16,463 (unduplicated) participants who attended and 86,858 individuals (duplicated) participated in at least one single service event

2-3
Alternative activity services were provided statewide by 22 Counties and 23 Tribes and 85 programs were implemented with a focus on alternatives. There were 1,108 (unduplicated) participants who attended at least one recurring services and 85,597 (duplicated) individuals participated in at least one single service event.

2-4
Services with a focus on problem identification and referral were provided statewide in 15 programs through 8 Counties, 3 Tribes, and the Office of the Superintendent of Public Instruction.. There were 15,883 (unduplicated) participants who attended at least one recurring service and 30,515 (duplicated) participated in at least one single service event. Most of the problem identification and referral services in

Washington State are provided by school-based Prevention & Intervention Specialists placed throughout the state.

2-5.1
Community based processes were implemented in 15 counties and 20 Tribes which provided 70 direct service programs. There were 1,764 (unduplicated) participants who attended at least one recurring service and 86,544(duplicated) individuals who participated in at least one single service event. An additional 882 Community-Based Coordination services were reported (862 from Counties and 20 from Tribes).

2-5.2
DBHR staff worked on several interagency workgroups. Most of the workgroups met on a month or bi-monthly schedule. The purposes of the workgroups were agency collaboration regarding trainings, conference planning, state survey implementation, and legislation. Those workgroups included, but were not limited to:

- Washington Interagency Network's Prevention Issues Workgroup,
- Governor's Advisory Committee on Substance Abuse Prevention and its various workgroups,
- Management Information System Advisory Workgroup
- Governor’s Council on Substance Abuse
- Washington State Prevention Summit Organizing Committee,
- Washington State Mentoring Partnership
- Washington State Partnership for Youth
- Washington State Healthy Youth Survey Implementation workgroup
- Washington State Youth Suicide Advisory Committee
- Washington’s State Mental Health Transformation Grant Prevention Advisory Committee
- Office of Superintendant of Public Instruction Drop-out Prevention Advisory Committee

2-5.3
Through contracts with 39 counties, Community Prevention Training System (CPTS) funding was used solely for training opportunities to increase capacity to implement science-based substance abuse prevention programming as identified in their Six Year County Strategic Plan and negotiated with their Regional Administrator. Trainings were completed by 972 County Prevention Specialists and their local providers which is down from the 2096 trained the previous year.

2-6
There were seven (7) environmental direct-service programs implemented with 89 (unduplicated) participants attending at least one recurring service and 4,942 (duplicated) individuals participated in at least one single service event. In addition, 60 Environmental activities were reported as Community-Based Coordination activities in the Prevention data system by the Counties and Tribes.

Goal 2
FY 2010 (Progress):

2.1.1
The Alcohol/Drug Information Clearinghouse is a major resource for alcohol, tobacco and other drug information for youth, parents, educators, law enforcement, and chemical dependency prevention and treatment professionals statewide. The Clearinghouse has been instrumental in: distributing 302,000 resources, staffing an exhibit for statewide conferences, providing materials to 92 events, and serving 400 visitors to the Resource Center.

2-1.2
The 2010 Prevention Summit provides a venue for awareness, knowledge and skill development and promotes motivation of prevention professionals and youth to continue work for prevention of problem behaviors.

Planning began in 2009 in preparation for the 2010 Summit to be held October 14-16, 2010 in Yakima Washington. Extensive planning has been conducted to develop training and collaboration opportunities for the field. In these times of "stretched" resources, it is critical that we continue to provide the field with valuable training opportunities such as the Prevention Summit.

DBHR contracts with University of Nevada, Reno Center for the Application of Substance Abuse Technologies for logistical support. Two DBHR Regional Prevention Managers have been assigned as the Conference Lead and Youth Track Lead to ensure the conference is implemented with success. The Conference Lead coordinates a Planning Committee to solicit broad community input and support. The Planning Committee consists of multiple agencies and organizations including, but not limited to:

- Office of the Attorney General Rob McKenna
- Washington State Coalition to Reduce Underage Drinking (RUaD)
- Washington State Strategic Prevention Framework State Incentive Grant (SPF-SIG)
- DBHR, Problem Gambling Program
- Washington State Department of Health, Tobacco Prevention & Control Program
- Office of Superintendent of Public Instruction (OSPI)
- TOGETHER!
- Department of Commerce
- Washington National Guard
- Educational Service District 105
- Educational Service District 123
- Okanogan Behavioral Healthcare
- Evergreen Council on Problem Gambling
- Prevention Specialist Certification Board of Washington
- Naches Valley Community Coalition
- Lewis County Social Services
- Center for Human Services Partners in Prevention
- Washington State Mentors
- Washington State Liquor Control Board
- DSHS, Juvenile Rehabilitation Administration
- Washington Association for Substance Abuse and Violence Prevention
- Lieutenant Governor Brad Owen

Conference planning is focused on program content and activities. Keynote and workshop presentations will include information on current and relevant topics such as; the impact of health care reform on prevention services, cutting edge research, and youth leadership development. Youth teams will participate in service learning projects and develop project plans for their local communities. Conference programs will consist of a variety of learning activities to include:;

- Youth team building activities (ropes course, dance, crafts, and YMCA games),
- Evening activities which include Native American storytelling, graphic recording and facilitating techniques, cultural dancing clinics and social-conscience film discussions,
- Professional networking opportunities, and
- Awards luncheon.

2-1.3
As of August 2010, the Alcohol/Drug Information Clearinghouse has produced 12 e-brief newsletters and distributed to 1,500 subscribers including prevention specialists, intervention specialists, and educators. The Clearinghouse staff attended our statewide prevention summit to ensure that they stay current on prevention research and resources.

2.1.4
Counties, as contractors, are given the choice of choosing information dissemination as a strategy. This strategy provides knowledge and increases awareness of the nature and extent of alcohol and other drug use, abuse and addiction, as well on individuals, families and communities. It also provides knowledge and increases awareness of available prevention and treatment program and services. As of August 2010, 5,000 activities have been reported.

2.2.1
The College Coalition (through a contract with the University of Washington) has more participating schools than ever before; with 37 separate schools having at least one representative in the coalition. A long standing goal has been to increase participation among two-year community and technical colleges, and we are proud to say that we now have representatives from twenty of these schools.

The College Coalition completed four professional development meetings. With our video-conference software we are able to confirm how many individual sites log in. At some schools, many people attend the webinar around a single computer or log-in. Hence, attendance is certainly not less than any of the numbers indicated, and is likely to be more. Details are below:

1) "Brief Motivational Interventions with High Risk Cohorts on College Campuses"
   Julie Lyzinski, University of Pennsylvania
   November 17, 2009
   20 user names logged in for webinar

2) "Systems Approach to College Drinking: Simulating the Effect of the Amethyst Initiative"
   Richard Scribner, LSU School of Public Health
   December 10, 2009
   14 user names logged in for webinar

3) "Beyond One Student At A Time: Community-Level Approaches to Underage Drinking Reduction"
   Lauri Turkovsky, DBHR
   April 1, 2010
   10 user names logged in for webinar

4) "Healthy Youth Survey…What Do Our Students Have To Say?"
Dixie Grunenfelder, OSPI
April 15, 2010
15 user names logged in for webinar

17 schools had the electronic Check Up to Go program on their campus.

2.2.2
Education programs have been provided statewide by 34 Counties and 15 Tribes. As of August 2010,a total of 190 programs have been implemented and reported with 16,354 (unduplicated) participants who attended at least one recurring service; and, 31,969 (duplicated) participated in at least one single service event.

Program Type	Count
Youth Education/skill building	92
Parenting Education	73
Peer Helper	9
Youth Leadership	7
Community Engagement	5
Other	4

2.2.3
In FFY2010, service and administrative data has been collected from 26 programs on 457 distinct mentor-mentee matches participating in 6,888 services.

2.3.1
Alternative programs have been provided statewide by 18 Counties and 19 Tribes. As of August FFY10, 62 programs have been implemented with a focus on alternatives with 1,893 (unduplicated) participants who have attended at least one recurring service; and 41,493 (duplicated) participated in at least one single service event.

2.4
To date for FFY10, 5 Counties, 1 Tribe, and the State Office of the Superintendent of Public Instruction have provided 8 programs with a focus on program identification and referral with 13,248 (unduplicated) individuals who attended at least one recurring service; and 7,693 (duplicated) participated in at least one single service event. Most of the problem identification and referral services in Washington State are provided by school-based Prevention & Intervention Specialists placed throughout the state.

2.5.1
As of August FFY10, 14 counties and 11 Tribes have provided 39 programs with a focus on community based processes which 1,521 (unduplicated) participants attended at least one recurring service; and 10,529 (duplicated) participated in at least one single service event. An additional 963 community-based coordination services have been reported (928 from Counties, 35 from Tribes).

Community Based Coordination Services by Type		
Service Type	**Count**	**Hours**
Community Capacity	670	9,833
Environmental Strategies	74	805
Funding	83	1,160

Media	136	4,626

2.5.2
DBHR staff work collaboratively with the following prevention partners:

- Washington State Inter-Agency Work Group to address hot topics and strategies during legislative sessions.
- Management Information System Advisory Workgroup to discuss a single multiagency prevention management information system
- Washington State Prevention Summit Planning Committee to plan and organize Washington State 2010 Prevention Summit.
- Washington State Mentoring Partnership to continue collaboration and support of statewide mentoring initiative and development of operating policies through
- Representatives from the Department of Health, Office of the Superintendant of
- Public Instruction, Department of Commerce, and the Liquor Control Board to development and discuss the content and implementation of multiple school based surveys through the 2010 Washington State Healthy Youth Survey.

2.5.3
DBHR supports local training opportunities that will increase capacity to implement evidence-based substance abuse prevention programming. As of August 2010, 1,150 people professionals have received trainings.

2.6
Due to the lack of evidence-based environmental strategies to choose from implementing environmental programs remain slow. As of August 2010, only 1 County and 2 Tribes have reported on 3 environmental programs which 819 (unduplicated) participants attended at least one recurring service; and, 980 (duplicated) participated in at least one single service event.

Goal #3: Providing specialized services for pregnant women and women with dependent children

An agreement to expend not less than an amount equal to the amount expended by the State for FY 1994 to establish and/or maintain new programs or expand and/or maintain the capacity of existing programs to make available treatment services designed for pregnant women and women with dependent children; and, directly or through arrangements with other public or nonprofit entities, to make available prenatal care to women receiving such treatment services, and, to make available child care while the women are receiving services (See 42 U.S.C. §300x-22(b)(1)(C) and 45 C.F.R. §96.124(c)(e)).

Note: In addressing this narrative the State may want to discuss activities or initiatives related to the provision of: *Prenatal care; Residential treatment services; Case management; Mental health services; Outpatient services; Education Referrals; Training/TA; Primary medical care; Day care/child care services; Assessment; Transportation; Outreach services; Employment services; Post-partum services; Relapse prevention; and Vocational services.*

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

Goal 3: FY 2011 - 2013 (Intended Use):

The goal for FFY 2011 – 2013 will be to treat the same number or more pregnant and parenting women than were treated in FFY 2010. 730 women were served in FFY 2009 (unduplicated count) and thus far for FFY 2010 (October 2009 to August 2010), 588 women were admitted into PPW residential treatment services. Treatment providers are expected to remain the same for the 2011 – 2013 biennium, with the same number of beds available (153 beds) pending any budget reductions. Services for pregnant and parenting woman in residential treatment will include:

- intensive inpatient and/or long term residential chemical dependency treatment;
- crisis and anger management; treatment and program rules compliance;
- medication & medical emergency management;
- situational parenting support and education and care of children;
- behavioral management;
- case management and social services;
- medical and health services;
- mental health services (typically referred outside the provider);
- re-entry preparation; and
- child services, including therapeutic childcare.

All data related to women in treatment will be entered in the Treatment and Report Generation Tool (TARGET) data system. Patients will be reevaluated at discharge to evaluate change of status and this data will be entered into TARGET. Treatment intervention will be individually based and congruent with race, ethnicity, age, gender, sexual preference, abuse histories, housing needs, and employment needs. **SAPT Block Grant dollars will not be used to fund Pregnant and Parenting Women (PPW) Residential treatment programs.** PPW Residential will be funded by state funds (for non-Medicaid patients and facilities larger than 16 beds) and Medicaid match (for Medicaid patients and facilities with 16 beds or less). PPW Residential beds will be considered a statewide resource and a woman will be able to access any PPW Residential program from anywhere in Washington State. If a woman is in need of transportation to and from residential treatment, and lives more than 50 miles from the facility, the residential provider will pay for this transportation and will be reimbursed by the appropriate funding source, either SAPT, State or Medicaid funds.

For FY2011-2013, our efforts will be concentrated on maintaining residential treatment of pregnant and parenting women in Washington State, despite ongoing budget reductions.

Residential treatment providers, specializing in services to pregnant and parenting women and their children, will continue to be contracted directly by DBHR. We plan to contract with ten (10) residential programs for pregnant and parenting women, for a total of 153 beds. This will equal the same number of beds provided in FY 2010.

Program Certification will continue to be monitored once every three years for compliance with requirements in the WAC 388-805 (http://apps.leg.wa.gov/wac/default.aspx?cite=388-805) by the DBHR Certification Section staff. Certification staff will monitor at least three of the PPW Residential facilities in each fiscal year. Identified findings will be presented in a corrective action plan letter to the provider. The provider, within a given time frame, is to respond to each finding identified and submit a corrective action plan back to DBHR. Any information related to the corrective action plan will be maintained in the Certification files.

All treatment contracts will be monitored on a biennial basis; therefore approximately one-half of the ten (10) programs will be monitored during each fiscal year by the DBHR Regional Treatment Managers

(RTM). The RTM will use a contract monitoring checklist, which has been updated to meet SAPT Block Grant requirements, (see attached Updated Contract Monitoring Checklist)and, to determine if the contractor is providing services per the Washington Administrative Code (WAC 388-805) and the PPW Residential contract. Identified findings will be presented in a corrective action plan letter to the provider. The provider, within a given timeframe, is to respond to each finding and submit a corrective action plan back to DBHR. Any information related to the corrective action plan will be placed in the DBHR contract file.

Utilization of funds and bed days will be monitored monthly by the RTM and the Family Services Manager. If a program does not fully utilize their monthly bed allocation, beds will be moved from an underutilized program to an overutilized program, on a one time only basis.

PPW providers (residential and outpatient) will make arrangements with other public and private entities for prenatal care statewide. We will continue to collaborate with Washington's First Steps program regarding prenatal care, case management and wrap around services. This requires that linkages be established between county governments and treatment providers. Providers will work with local medical providers and hospitals to develop relationships for prenatal referral options for their patients. We will continue to participate in First-Steps provider workgroups to monitor continued collaboration.

Childcare will be provided and/or arranged while women receive treatment statewide. We will contract directly with specialized residential treatment programs, for women with children, to provide therapeutic childcare. Counties throughout the state will be required, by contract, to provide and/or arrange for childcare for parents in outpatient treatment:

Outpatient contracts will read:

a. Childcare and Prenatal Care:

The County shall, directly or through arrangements with other public or nonprofit private entities, make available prenatal care to women and childcare to patients receiving treatment services.

Adult Residential contracts will read:

(1) Childcare and Prenatal Care Required: The Contractor shall, directly or through arrangements with other public or nonprofit private entities, make available prenatal care and childcare to parents receiving treatment services.

Treatment providers will provide funding for childcare for their outpatient patients, while others will rely on referrals and arrangements with local childcare providers, with payment coming from other sources such as Children's Administration, self pay, and reduced fee. Therapeutic childcare will be available at 9 of the 10 PPW Residential programs. Children through the age of five will be allowed to room with their mother who is in PPW Residential treatment.

Therapeutic Childcare will be monitored on a monthly basis. Programs will be required to submit a monthly childcare report to the contract manager that includes:

a. The number of children admitted and discharged
b. The total number of hours of care provided
c. The unduplicated count of the number of children served.

Goal 3: FY 2008 (Compliance):

Introduction: The goal for FY 2008 was to treat equal to or more pregnant and parenting women than were treated in FY 2007 (702 women) for this population. All ten (10) treatment PPW residential providers received contracts during the 2007 – 2009 biennium which equaled 153 beds available. Contract language ensured that providers gave priority admission to pregnant and parenting women:

For County and Tribal contracts:

Pregnant and Parenting Women.

The County shall ensure pregnant and parenting women in need of treatment or who are referred for treatment shall be given admission preference to treatment facilities receiving block grant funds.

For Adult Residential contracts:

Ensure treatment admissions are prioritized as follows

(a) Parent with a child under eighteen years old in the home

(b) Patient referred by the department's Child Protective Services (CPS) program

(c) Intravenous injecting drug user (IVDU)

Ensure that priority to admission is given to:

(1) Pregnant Women;

(2) Intravenous Drug Users (IDUs);

(3) Persons infected with HIV/AIDS;

(4) Parents with children in the home; and

(5) Child Protective Service (CPS) referrals.

Services for pregnant and parenting women in residential treatment included: intensive inpatient and/or long term residential chemical dependency treatment; crisis and anger management; treatment and program rules compliance; medication & medical emergency management; situational parenting support and education and care of children; and behavioral management; case management and social services; medical and health services; mental health services (typically referred outside the provider); re-entry preparation; child services, including therapeutic childcare. Patients from anywhere in the state could access any of the 10 PPW residential treatment programs.

All data related to the women in treatment was entered in the Treatment and Report Generation Tool (TARGET) data system. However, data from outside providers was not collected. Data was re-entered at discharge to show change of status. In FFY 2008, 662 women were admitted to PPW Residential treatment and 53.6% of the women that entered treatment completed successfully. Treatment intervention was individually based and was congruent with race,

ethnicity, age, gender, sexual preference, abuse histories, housing needs, and employment needs. SAPT Block Grant dollars were not used to fund Pregnant and Parenting Women (PPW) Residential treatment programs. Funding source for PPW Residential services was state funds (for non-Medicaid eligible patients and facilities larger than 16 beds) and Medicaid match (for Medicaid eligible patients and facilities with 16 beds or less). All Therapeutic Childcare within the PPW Residential programs was funded with Medicaid match. PPW Residential beds were considered a statewide resource and a woman was able to access any PPW Residential program from anywhere in Washington State. Residential providers were reimbursed, by DBHR, for transportation costs incurred by a woman in need of transportation to and from residential treatment, and who lived more than 50 miles from the facility. Medicaid transportation was available to women on Medicaid within their community for outpatient treatment services.

The goal for FY 2008 was to increase or maintain capacity statewide for residential treatment of pregnant and parenting women in Washington State. DBHR maintained the PPW residential treatment capacity (10 providers with a total of 153 beds). With no new resources available, DBHR was unable to increase or expand capacity for treatment services. However, DBHR was able to expand support services to pregnant and parenting women by adding two new Parent Child Assistance Programs (PCAP) (see attachment) in Clallam and Kitsap Counties. The sites began services July 1, 2008. The Clallam site had a capacity of 30 women ($163,128/year) and the Kitsap site had a capacity of 60 women ($291,648/year). Each site built capacity over time. General state funds were used for PCAP.

Residential treatment providers, specializing in services to pregnant and parenting women and their children, were contracted directly with DBHR. During FY 2008, there were ten (10) residential programs for pregnant and parenting women, for a total of 153 beds. This equaled the same number of beds provided in FY 2007.

Program Certification was monitored once every three years for compliance with requirements in the WAC 388-805 (http://apps.leg.wa.gov/wac/default.aspx?cite=388-805) by the DBHR Certification Section staff which equaled approximately one-third (3 providers) of the PPW Residential facilities in FY 2008. Findings identified by Program Certification staff included (not a complete list): poor treatment planning; not enough treatment plan reviews; diagnostic assessment does not support current level of care; written summary of overall level of care did not support American Society of Addiction Medicine (ASAM) level of care. Findings identified by the DBHR Certification Section were presented in a corrective action plan letter to the provider. The provider, within the specified time frame, responded to each identified finding and submitted a corrective action plan back to DBHR. All findings identified during the on-site reviews have been corrected. Once the corrective action plan was met, any information related to the corrective action plan was placed in the Certification files.

Approximately one-half (5 providers) were monitored in FY 2008 by the DBHR Regional Treatment Managers (RTM). The contract managers used a contract monitoring checklist (see attached Contract Monitoring Checklist) to determine if the contractor was providing services per the Washington Administrative Code (WAC 388-805) and the PPW Residential contract (see attached PPW Residential contract). Findings identified by the contract monitoring checklist included (not a complete list): Medicaid billing errors; multiple billing errors; background checks of treatment staff missing in personnel file; TARGET data errors.

Of the providers who had an on-site monitoring review by the Regional Treatment Manager, approximately one-half of those providers had mostly minor issues that were easily remedied.

Findings identified by the DBHR Regional Treatment Manager were presented in a corrective action plan letter to the provider. The provider, within the specified timeframe, responded to each finding identified and submitted a corrective action plan back to DBHR. All findings identified during the on-site reviews have been corrected. Once the corrective action plan was met, any information related to the corrective action plan was placed in the DBHR contract file.

Utilization of funds and bed days were monitored monthly by the Contract Manager (RTM) and the Family Services Manager. If a program did not fully utilize their bed allocation, bed allocations were redistributed from an underutilized program to an overutilized program, on a one-time only basis. Bed moves took place every other month. Not all programs experienced under or overutilization, but the majority of providers experienced bed moves throughout the fiscal year. Eleven adjustments to beds were made in FY 2008, in 9 of the 10 programs.

The budget for PPW Residential treatment services (153 beds statewide) was $14,039,453 for the 2007-2009 biennium ($7,029,330 or State Fiscal Year 2008). Six (6) of the ten (10) programs were Medicaid match facilities.

In FFY 2008, 652 unduplicated women were admitted into PPW residential treatment services (131 intensive inpatient and 531 long-term residential), with 53.6% completing treatment successfully.

PPW providers (residential and outpatient) arranged with other public and private entities for prenatal care statewide. DBHR continued to collaborate with Washington's First Steps program regarding prenatal care, case management and wrap around services. This activity required linkages be established between county governments and treatment contract providers. Providers worked with local medical providers and hospitals to develop relationships for prenatal referral options for their patients. DBHR participated in First-Steps provider workgroups to ensure continued collaboration.

The goal for FY 2008 was to provide and/or arrange for childcare while women received treatment statewide. DBHR contracted directly with specialized residential treatment programs (see PPW Residential contract/Therapeutic Childcare section, beginning on page 30 - attachment) for women with children to provide therapeutic childcare, and counties throughout the state to provide and/or arrange for childcare when parents were receiving outpatient treatment services:

Counties contract language stated:

a. Childcare and Prenatal Care:

The County shall, directly or through arrangements with other public or nonprofit private entities, make available prenatal care and childcare to women receiving treatment services.

Adult Residential:

(1) Childcare and Prenatal Care Required: The Contractor shall, directly or through arrangements with other public or nonprofit private entities, make available prenatal care and childcare to parents receiving treatment services.

The amount of funding by the counties and tribes for childcare varied. Some outpatient treatment entities provided funding for childcare for their patients, while others relied on referrals

and arrangements with local childcare providers, with payment coming from other sources such as Children's Administration, self pay, and reduced fee. Therapeutic childcare was available at 9 of the 10 PPW Residential programs. Children, through the age of five, were allowed to room with their mother who was in PPW Residential treatment.

In FY 2008, 533 children were served within the nine PPW Residential treatment programs and the one outpatient program (Childhaven) in King County, for a total of $1,304,102.

Therapeutic Childcare was monitored on a monthly basis by the PPW Residential programs. Programs were required to submit a monthly childcare report to the contract manager that included:

b. The number of children admitted and discharged
c. The total number of hours of care provided
d. The unduplicated count of the number of children served.

The budget for Therapeutic Childcare (130 slots statewide) in the PPW residential system was $3,352,960 for the 2007-2009 biennium ($1,676,480 for State Fiscal Year 2008). All Therapeutic Childcare was Medicaid match.

Goal 3: FY 2010 (Progress):

Introduction: The goal for FFY 2010 is to treat equal to or more pregnant and parenting women (PPW) than were treated in FFY 2009 for this population (730 - unduplicated count). At the beginning of the 2009-2011 biennium the same residential treatment for the 2007 – 2009 biennium received contracts with the same number of beds available (153 beds). Unfortunately, in March 2010, Perinatal Pierce closed their facility. Those beds were transferred to other PPW treatment providers across the state in order to maintain capacity during FY 2010. The funds have been re-contracted Triumph Treatment Services (TTS) who has two other PPW residential programs. This program will have an innovative and dynamic opportunity on the grounds of the new facility. Currently, TTS has one PPW residential program, a new program will be added, and they are likely to move another PPW residential (from another city) onto the same grounds. The new facility is likely to open in October 2010. The timeframe for moving the program from the other city it unknown at this time. Each program will be in its own building, separate and distinct from each other, and the programs will share a childcare facility. TTS plans to have different levels of care and lengths of stay to best meet the needs of each individual patient.

Contract language continues to ensure that providers give priority admission to pregnant and parenting women. Services for pregnant and parenting woman in residential treatment include:

- intensive inpatient and/or long term residential chemical dependency treatment;
- crisis and anger management; treatment and program rules compliance;
- medication & medical emergency management;
- situational parenting support and education and care of children;
- behavioral management;
- case management and social services;
- medical and health services;
- mental health services (typically referred outside the provider);
- re-entry preparation; and
- child services, including therapeutic childcare.

Patients from anywhere in the state can access any of the PPW residential treatment programs.

All data related to the women in treatment is entered in the Treatment and Report Generation Tool (TARGET) data system. The patient is reevaluated at discharge to allow measurement of change of status.

Treatment intervention is individually based and is congruent with race, ethnicity, age, gender, sexual preference, abuse histories, housing needs, and employment needs. **SAPT Block Grant dollars are not used to fund Pregnant and Parenting Women (PPW) Residential treatment programs.** PPW Residential is funded by state funds (for non-Medicaid patients and facilities larger than 16 beds) and Medicaid match (for Medicaid patients and facilities 16 beds or less). PPW Residential beds are considered a statewide resource and a woman is able to access any PPW Residential program from anywhere in Washington State. If a woman is in need of transportation to and from residential treatment, and lives more than 50 miles from the facility, the residential providers pay for this transportation and is reimbursed by DBHR. Transportation is available to women on Medicaid within their community for outpatient treatment services.

We have maintained the PPW residential treatment capacity for FFY 2010, even in light of budget reductions to treatment services and the closure of one program.

DBHR contracts directly with residential treatment providers, specializing in services to pregnant and parenting women and their children. For FFY 2010, there are ten (10) residential programs for pregnant and parenting women, for a total of 153 beds. This equals the same number of beds provided in FY 2009.

Through August 2010 Program Certification staffs have monitored 3 of the 1o PPW residential providers for compliance with requirements in the WAC 388-805 (388-805 (http://apps.leg.wa.gov/wac/default.aspx?cite=388-805). Findings identified by Certification Staff include (not a complete list):

- poor treatment planning;
- not enough treatment plan reviews;
- diagnostic assessment does not support current level of care; and
- written summary of overall level of care did not support American Society of Addiction Medicine (ASAM) level of care.

The provider, within a given time frame, will respond to each finding identified and submits a corrective action plan back to DBHR. Any information related to the corrective action plan is placed in the Certification files.

All treatment programs are being monitored at least once during the contract period by the DBHR Regional Treatment Manager (RTM). As of August 2010, 5 providers have been monitored. The RTM use a contract monitoring checklist (see attached Contract Monitoring Checklist) to determine if the contractor is providing services per the Washington Administrative Code (WAC 388-805) and the PPW Residential contract (see attached PPW Residential contract). Findings identified by the contract monitoring checklist include (not a complete list):

- Medicaid billing errors;
- multiple billing errors;
- background checks of treatment staff missing in personnel file; and
- TARGET data errors.

At least two of the providers had findings, mostly minor issues which are easily remedied. Findings are presented in a corrective action plan letter to the provider. The provider, within a given timeframe, responds to each finding identified and submits a corrective action plan back to DBHR. Once the corrective action plan is met, any information related to the corrective action plan is placed in the DBHR contract file.

Utilization of funds and bed days are monitored monthly by the RTM and the Family Services Manager. Bed allocations are moved from an underutilized program to an overutilized program, on a one time only basis. Not all programs will experience an under or overutilization, but the majority of providers experience bed moves throughout the fiscal year. So far (October 2009 to September 2010), 36 adjustments to bed allocations have been made in all 10 programs.

The current budget for PPW Residential treatment services (153 beds statewide) is $14,020,246 for the 2009-2011 biennium ($7,010,123 for State Fiscal Year 2010). Six (6) of the ten (10) programs are Medicaid match facilities.

Thus far for FFY 2010 (October 2009 to August 2010), 588 women were admitted into PPW residential treatment services (156 intensive inpatient and 452 long-term residential), with 66% completing treatment successfully, a marked improvement over the FFY 2008 completion rates (54%). It is expected that another 50 to 100 women will be admitted during the last 4 months of FFY 2010.

DBHR and PPW providers (residential and outpatient) have made arrangements with public and private entities for prenatal care statewide. We are continuing to collaborate with Washington's First Steps program for prenatal care, case management and wrap around services. Linkages are established between county governments and treatment contract providers. Providers are working with local medical providers and hospitals to develop prenatal referral options for their patients. We are continuing to participate in First-Steps provider workgroups to ensure continued collaboration.

We have direct contracts with specialized residential treatment programs (see PPW Residential contract/Therapeutic Childcare section, beginning on page 30 - attachment) for women with children to provide therapeutic childcare. Outpatient providers are required to provide and/or arrange for childcare for parents in outpatient treatment:

Outpatient contract language reads:

a. Childcare and Prenatal Care:

The County shall, directly or through arrangements with other public or nonprofit private entities, make available prenatal care and childcare to women receiving treatment services.

Adult Residential contract language reads:

(1) Childcare and Prenatal Care Required: The Contractor shall, directly or through arrangements with other public or nonprofit private entities, make available prenatal care and childcare to parents receiving treatment services.

Some counties and tribes provide funding for childcare for their outpatient patients, while others are relying on other sources such as Children's Administration, self pay, and reduced fee. Therapeutic childcare is available at 9 of the 10 PPW Residential programs. Children, through the age of five, are allowed to room with their mother who is in PPW Residential treatment.

Programs submit a monthly childcare report to the RTM that includes:

- The number of children admitted and discharged
- The total number of hours of care provided
- The unduplicated count of the number of children served.

The current budget for Therapeutic Childcare (130 slots statewide) in the PPW residential system is $3,352,960 for the 2009-2011 biennium ($1,676,480 for State Fiscal Year 2010). All Therapeutic Childcare was Medicaid match.

Programs for Pregnant Women and Women with Dependent Children (formerly Attachment B)

(See 42 U.S.C. §300x-22(b); 45 C.F.R. §96.124(c)(3); and 45 C.F.R. §96.122(f)(1)(viii))

For the fiscal year three years prior (FY 2008; Annual Report/Compliance) to the fiscal year for which the State is applying for funds:

Refer back to your Substance Abuse Entity Inventory (Form 9 formerly Form 6). Identify those projects serving **pregnant women and women with dependent children** and the types of services provided in FY 2008. In a narrative of **up to two pages**, describe these funded projects.

Title XIX, Part B, Subpart II, of the PHS Act required the State to expend at least 5 percent of the FY 1993 and FY 1994 block grants to increase (relative to FY 1992 and FY 1993, respectively) the availability of treatment services designed for pregnant women and women with dependent children. In the case of a grant for any subsequent fiscal year, the State will expend for such services for such women not less than an amount equal to the amount expended by the State for fiscal year 1994.

In up to four pages, answer the following questions:

1. Identify the name, location (include sub-State planning area), Inventory of Substance Abuse Treatment Services (I-SATS) ID number (formerly the National Facility Register (NFR) number), level of care (refer to definitions in Section III.4), capacity, and amount of funds made available to each program designed to meet the needs of pregnant women and women with dependent children.

2. What did the State do to ensure compliance with 42 U.S.C. §300x-22(b)(1)(C) in spending FY 2008 Block Grant and/or State funds?

3. What special methods did the State use to **monitor** the adequacy of efforts to meet the special needs of pregnant women and women with dependent children?

4. What sources of data did the State use in estimating treatment capacity and utilization by pregnant women and women with dependent children?

5. What did the State do with FY 2008 Block Grant and/or State funds to establish new programs or expand the capacity of existing programs for pregnant women and women with dependent children?

Programs for Pregnant Women and Women with Dependent Children (See 42 U.S.C. 300x-22(b); 45 C.F.R. 96.124(c)(3); and 45 C.F.R. 96.122(f)(1)(viii))

For the fiscal year three years prior (FY 2008) to the fiscal year for which the State is applying for funds: Refer back to your Substance Abuse Entity Inventory (Form 6). Identify those projects serving **pregnant women and women with dependent children** and the types of services provided in FY 2008. In a narrative of **up to two pages**, describe these funded projects.

Services provided to high-risk substance abusing women and their young children include referral, support, and advocacy for substance abuse treatment and relapse prevention; and accessing and using local resources such as family planning, safe housing, health care, domestic violence services, parenting skill training, child welfare, child care, transportation, and legal services. Specialized long-term residential and outpatient treatment programs served the highest-risk substance abusing women and their children. Pregnant and Parenting Women (PPW) were given priority status for publicly funded chemical dependency treatment in Washington State.

Safe Babies Safe Moms (see attachment) and the Parent Child Assistance Programs (PCAP) (see attachment) are two programs that served pregnant and parenting women. Both are three-year case management programs that provide a comprehensive range of services, with a goal of stabilizing women and their young children, identifying and providing necessary interventions, and assisting women in gaining self-confidence as they transition from public assistance to self-sufficiency. DBHR expanded support services to pregnant and parenting women by adding two new PCAP sites in Clallam and Kitsap Counties. The sites began services July 1, 2008. The Clallam site has a capacity of 30 women ($163,128/year) and the Kitsap site has a capacity of 60 women ($291,648/year). Each site built capacity over time. General state funds were used for PCAP.

Parent Trust, supported by DBHR, offers unique solutions for the entire family through effective, workshops and coaching. The Division's funding placed Parent Trust counselors in the PPW Residential programs to provide additional support and encouragement to the parenting mother.

Housing Support Services (see attachment) are services in alcohol- and drug-free residences provided for women and their children for up to 18 months. Recovery support and linkages to community-based services were provided. These included an initial needs assessment coordinated with a treatment provider and the woman to determine current need for services. A care plan was developed with the woman to identify community supports to maximize her recovery plan. Case management was provided to monitor for substance abuse and participation in outpatient substance abuse treatment, and to facilitate linkages and appointments for prenatal and post-natal medical care, financial assistance, social services, vocational services, childcare needs, and permanent housing.

The Fetal Alcohol Syndrome Diagnostic and Prevention Network (see FAS attachment) is a statewide network of five clinical sites located in Spokane, Yakima, Pullman, and Everett, with a core-training site at the University of Washington in Seattle. The network provided diagnostic and treatment referral services to individuals of all ages with fetal alcohol exposure; FAS screening and surveillance for high-risk populations; identification and referral of high-risk mothers to primary prevention and intervention programs; training and education to professionals statewide; and information retrieval to support FAS clinical research.

The Fetal Alcohol Syndrome Family Resource Institute (FASFRI) is a grassroots non-profit organization of parents working together with professionals to identify and care for individuals and families with FAS and FAE. The Institute holds seminars on FAS/FAE, and manages a crisis information phone line.

The Fetal Alcohol Syndrome Information Services produced a newsletter called *Iceberg,* targeted at parents with fetal alcohol affected children. DBHR funded the development and distribution of this newsletter. This newsletter can be found at: http://www.fasiceberg.org/

Epic Crisis Nursery is located in Yakima, Washington and provided therapeutic childcare, crisis childcare, and respite childcare to substance abusing parenting women.

Ongoing assessment for chemical dependency was designed to identify needs through systematic collection of data to determine current status and needs in fiscal, environmental, psychosocial, developmental, educational, behavioral, emotional, and mobility areas. Treatment is individually determined based on these needs.

Specialized long-term residential care included structured clinical services staffed by qualified addiction treatment personnel who provided a planned regimen of patient care in a 24-hour live-in setting. Specialized PPW programs offered a number of enhancements, including the availability of therapeutic childcare for children under six (one or more children may participate while the mother is in treatment). Therapeutic childcare (see attachment) provided for the health and welfare of the children accompanying parents who participated in the residential substance abuse program. Services were for the care, protection, and treatment of children who are at risk of abuse, neglect, and eventual substance abuse. Services included the following elements: 1) developmental assessment using recognized, standardized instruments; 2) play therapy; 3) behavioral modification; 4) individual counseling; 5) self-esteem building; and 6) family intervention to modify parenting behavior and/or the child's environment to eliminate/prevent the child's dysfunctional behavior. Childcare was provided at a minimum of four (4) hours per day, five days per week. Additional services in PPW residential treatment included a focus on domestic violence, childhood sexual abuse, linkage to medical care and legal advocacy, parenting education, mental health issues, employment skills and education, and safe, affordable housing.

First Steps is a collaborative program with the Department of Social and Health Services and the Department of Health. This program provides services to pregnant, substance abusing women and their children by enhancing perinatal services through Washington's First Steps Maternity Case Management Program and by integrating and coordinating maternity care services with comprehensive substance abuse intervention services. Key program components included outreach, training for prenatal care providers, standard screening to identify pregnant substance abusers, parenting education, case management, and substance abuse treatment in residential settings. Targeted activities included: maintaining linkages between the state's Medicaid agency, and substance abuse and health agencies; screening based on a standardized protocol and uniform training in how to screen, within a variety of traditional and nontraditional providers and agencies; referral to on-call outreach workers trained in substance abuse counseling; a continuum of care to include: prenatal care, detoxification, intensive substance abuse treatment, and follow-up outpatient care for at least three months; education and training on Fetal Alcohol Spectrum Disorders for chemical dependency treatment providers.

Title XIX, Part B, Subpart II, of the PHS Act required the State to expend at least 5 percent of the FY 1993 and FY 1994 block grants to increase (relative to FY 1992 and FY 1993, respectively) the availability of treatment services designed for pregnant women and women with dependent children. In the case of a grant for any subsequent fiscal year, the State will expend for such services for such women not less than an amount equal to the amount expended by the State for fiscal year 1994.

In up to four pages, answer the following questions:

1. Identify the name, location (include sub-State planning area), Inventory of Substance Abuse Treatment Services (I-SATS) ID number (formerly the National Facility Register (NFR) number), level of care (refer to definitions in Section II.4), capacity, and amount of funds made available to each program designed to meet the needs of pregnant women and women with dependent children.

2. What did the State do to ensure compliance with 42 U.S.C. 300x-22(b)(1)(C) in spending FY 2008 Block Grant and/or State funds?

3. What special methods did the State use to **monitor** the adequacy of efforts to meet the special needs of pregnant women and women with dependent children?

4. What sources of data did the State use in estimating treatment capacity and utilization by pregnant women and women with dependent children?

5. What did the State do with FY 2008 Block Grant and/or State funds to establish new programs or expand the capacity of existing programs for pregnant women and women with dependent children?

1. Identify the name, location (include sub-State planning area), Inventory of Substance Abuse Treatment Services (I-SATS) ID number (formerly the National Facility Register

(NFR) number), level of care (refer to definitions in Section II.4), capacity, and amount of funds made available to each program designed to meet the needs of pregnant women and women with dependent children.

The following agencies provided residential treatment services for pregnant and parenting women (fund amounts are approximate):						
Name	Location	Sub-State Planning Area	ISAT Number	Level of Care	Capacity	Amount of Funds
ISABELLA HOUSE – NEW HORIZONS CARE CENTER	Spokane,	Spokane	WA 904637	Residential Long Term/Intensive Inpatient	24 Adult, 21 Children	$975,534 (General Fund State)
DRUG ABUSE PREVENTION CENTER	Kelso	Cowlitz	WA 101473	Residential Inpatient and Long Term	16 adults and 16 children	$668,312 (General Fund State and Medicaid)
GENESIS HOUSE	Seattle	King	WA 100079	Residential/Inpatient Services	13 adults and 14 children	$639,780 (General Fund State)
PERINATAL TREATMENT SERVICES - KING	Seattle	King	WA 101374	Residential Inpatient Services	26 adults and 18 children	$1,140,924 (General Fund State)
PERINATAL TREATMENT SERVICES - PIERCE	Tacoma	Pierce	WA 101374	Residential Inpatient Services	16 adults and 16 children	$669,377 (General Fund State and Medicaid)
EVERGREEN MANOR – UNIT ONE	Everett	Snohomish	WA 100385	Residential Services	12 adult and 6 children	$471,074 (General Fund State and Medicaid)
EVERGREEN MANOR – Residential Services UNIT TWO	Everett	Snohomish	WA 100385	Residential Services	9 adults and 9 children	$379,085 (General Fund State and Medicaid)
SUNDOWN M RANCH	Yakima	Yakima	WA 904835	Intensive Inpatient Services	7 adults	$237,581 (General Fund State)
YAKIMA VALLEY COUNCIL/TRIUMPH TREATMENT SERVICES Casita del Rio	Yakima	Yakima	WA100661	Residential Services	15 adults and 15 children	$697,435 (General Fund State and Medicaid)
YAKIMA VALLEY COUNCIL/TRIUMPH TREATMENT SERVICES Riel House	Yakima	Yakima	WA101408	Residential Services	15 adults and 15 children	$637,767 (General Fund State and Medicaid)
The following agencies provided housing support services for pregnant and parenting women (funded by SAPT Block Grant):						
ACTION ASSOCIATION Another Chance for Women	Tacoma	Pierce	WA 101879	Housing Support Services	12 Adults	$110,554 (SAPT funds)

KOINONIA INN Program of AGAPE Unlimited	Bremerton	Kitsap	WA 100327	Housing Support Services	6 Adults, 6-8 children	$23,650 (SAPT funds)
NEW HORIZON'S CARE CENTER	Spokane	Spokane	WA 100478	Housing Support Services	10 Adults	$16,410 (SAPT funds)
TREE OF LIFE Catholic Community Services of Western Washington	Everett	Snohomish	WA 100392	Housing Support Services	37 Adults	$131,268 (SAPT funds)
EVERGREEN MANOR	Everett	Snohomish	WA 100385	Housing Support Services	10 Adults	$66,102 (SAPT funds)
BRIGID COLLINS HOUSE	Bellingham	Whatcom	X	Housing Support Services	5 Adults	$27,678 (SAPT funds)
DRUG ABUSE PREVENTION CENTER	Kelso	Cowlitz	WA 101473	Housing Support Services	6 adults	$25,622 (SAPT funds)
RECOVERY CENTERS OF KING COUNTY	Seattle	King	WA 105318	Housing Support Services	25 adults	$81,651 (SAPT funds)
YAKIMA VALLEY COUNCIL/TRIUMPH TREATMENT SERVICES Parkway Place	Yakima	Yakima	WA105409	Housing Support Services	28 adults	$93,331 (SAPT funds)
YAKIMA VALLEY COUNCIL/TRIUMPH TREATMENT SERVICES Casita del Rio	Yakima	Yakima	WA100661	Housing Support Services	4 adults	$14,824 (SAPT funds)
YAKIMA VALLEY COUNCIL/TRIUMPH TREATMENT SERVICES Sage House	Yakima	Yakima	WA105409	Housing Support Services	6 adults	$39,991 (SAPT funds)
The following agencies provided support/case management-type services for pregnant and parenting women (fund amounts are approximate):						
UNIVERSITY OF WASHINGTON	Seattle	King	X	FAS Diagnostic and Prevention Network	50 individuals per year	$354,050 (General Fund State)
UNIVERSITY OF WASHINGTON	Seattle	King and Pierce Counties	X	Parent Child Assistance Program (PCAP)	180 women and their children	$1,308,095 (General Fund State, State TANF)
SPOKANE REGIONAL HEALTH DISTRICT	Spokane	Spokane	X	Parent Child Assistance Program (PCAP)	95 women and their children	$197,934 (General Fund State)
DRUG ABUSE PREVENTION CENTER	Kelso	Cowlitz	WA101473	PCAP	95 women and their children	$387,715 (General Fund State)
SKAGIT RECOVERY CENTER	Mount Vernon	Skagit	WA750261	PCAP	60 women and their children	$278,385 (General Fund State)

YAKIMA VALLEY COUNCIL	Yakima	Yakima	WA105409	PCAP	95 women and their children	$387,715 (General Fund State)
GRANT COUNTY	Moses Lake	Grant	WA750931	PCAP	30 women and their children	$155,711 (General Fund State)
PARENT TRUST FOR WA CHILDREN	Seattle	King	X	Support Services	Groups in 8 PPW Res Tx Agencies	$100,008 (General Fund State)
BRIGID COLLINS HOUSE	Bellingham	Whatcom	X	Safe Babies Safe Moms (SBSM)	70 women and their children	$450,240 (General Fund State and Medicaid)
PACIFIC TREATMENT ALTERNATIVES	Everett,	Snohomish	X	Safe Babies Safe Moms (SBSM)	112 women and their children	$720,384 (General Fund State and Medicaid)
BENTON-FRANKLIN HEALTH DISTRICT	Kennewick	Benton	X	Safe Babies Safe Moms (SBSM)	68 women and their children	$437,376 (General Fund State and Medicaid)
The following agencies provided outpatient treatment and support services for pregnant and parenting women with SAPT BG funds:						
LOURDES CD PROGRAM	Pasco	Franklin	WA904470	Outpatient Treatment Services	Only limited by funding	$773
WEST END OUTREACH SERVICES FORKS	Forks	Clallam	WA750154	Outpatient Treatment Services	Only limited by funding	$5,109
BLUE MOUNTAIN COUNSELING	Dayton	Columbia	WA105219	Outpatient Treatment Services	Only limited by funding	$120
GRANT COUNTY PREVENTION AND RECOVERY	Moses Lake	Grant	WA750931	Outpatient Treatment Services	Only limited by funding	$22,716
CENTER FOR HUMAN SERVICES	Shoreline	King	WA903621	Outpatient Treatment Services	Only limited by funding	$10,718
NEW TRADITIONS	Seattle	King	WA101681	Outpatient Treatment Services	Only limited by funding	$15,031
PUBLIC HEALTH DEPARTMENT	Seattle	King	X	Support Services	Only limited by funding	$47,004
RECOVERY CENTER OF KING COUNTY	Seattle	King	WA750501	Outpatient Treatment Services	Only limited by funding	$77,033
THERAPEUTIC HEALTH SERVICES	Bellevue	King	WA104105	Outpatient Treatment Services	Only limited by funding	$61,190
LINCOLN COUNTY ALCOHOL/DRUG CTR	Davenport	Lincoln	WA902490	Outpatient Treatment Services	Only limited by funding	$3,503
PEND OREILLE COUNTY COUNSELING SRVCS	Newport	Pend Oreille	WA902771	Outpatient Treatment Services	Only limited by funding	$1,765
VOLUNTEERS OF AMERICA	Everett	Snohomish	X	Support Services	Only limited by funding	$17,750
SKAGIT RECOVERY	Mt Vernon	Skagit	WA750261	Outpatient Treatment Services	Only limited by funding	$541
COMMUNITY MINDED ENTERPRISES	Spokane	Spokane	X	Support Services	Only limited by funding	$83,884
BEHAVIORAL HEALTH RESOURCES	Olympia	Thurston	WA900783	Outpatient Treatment Services	Only limited by funding	$138,013
AGAPE UNLIMITED	Bremerton	Kitsap	WA100327	Outpatient Treatment Services	Only limited by funding	$9,990
SKAMANIA COUNTY	Skamania	Skamania	WA104865	Outpatient Treatment Services	Only limited by funding	$28
PROVIDENCE ADDICTION RECOVERY CENTER	Everett	Snohomish	WA100715	Outpatient Treatment Services	Only limited by funding	$6,364

COMPASS	Coupeville	San Juan	WA100968	Outpatient Treatment Services	Only limited by funding	$8,895
TRUE NORTH – ESD 113	Tumwater	Thurston	WA000105	Outpatient Treatment Services	Only limited by funding	$690
PALOUSE RIVER COUNSELING	Pullman	Whitman	WA750956	Outpatient Treatment Services	Only limited by funding	$587
OKANOGAN BEHAVIORAL HEALTH	Omak	Okanogan	WA751129	Outpatient Treatment Services	Only limited by funding	$1,917
EUGENIA CENTER	Chehalis	Lewis	WA102489	Outpatient Treatment Services	Only limited by funding	$7,105
PHOENIX REOCOVERY	Mt Vernon	Skagit	WA100791	Outpatient Treatment Services	Only limited by funding	$507
PIONEER CENTER NORTH	Sedro Woolley	Skagit	WA903035	Outpatient Treatment Services	Only limited by funding	$119
ALCOHOL AND DRUG DEPENDENCY SERVICES	Ellensburg	Kittitas	WA750121	Outpatient Treatment Services	Only limited by funding	$615
TACOMA PIERCE COUNTY HEALTH	Tacoma	Pierce	WA102570	Outpatient Treatment Services	Only limited by funding	$22,414
UNITY COUNSELING	Pasco	Franklin	WA101507	Outpatient Treatment Services	Only limited by funding	$1,219
REGIONAL TOXICOLOGY – STERLING LAB	Seattle	King	X	Urinalysis Services	Only limited by funding	$14
NORTHEAST WASHINGTON ALLIANCE COUNSELING	Chewelah; Colville; Republic	Stevens; Ferry	WA103693	Outpatient Treatment Services	Only limited by funding	$150

X = non-treatment provider/no I-SATS number

2. What did the State do to ensure compliance with 42 U.S.C. 300x-22(b)(1)(C) in spending FY 2008 Block Grant and/or State funds?

Funds required to be spent under 42 U.S.C. 300X-22(b)(1)(C) are identified separately through the Agency Financial Reporting System (AFRS) accounting for the women's maintenance of effort requirement. Women's expenditures are entered with separate index codes and allocation codes that are being tracked through the Division of Behavioral Health and Recovery Cost Allocation Plan Schedule.

In addition to making pregnant women a priority and serving women in standard alcohol and other drug abuse treatment, DBHR had a continuum of specialized treatment activities designed especially for women. This continuum included case finding and outreach to pregnant and postpartum women, fast track assessment, outpatient treatment, referral to prenatal care, intensive inpatient treatment, long term treatment, aftercare, and housing support services. In FFY 2008, a total of 1,633 pregnant and/or parenting women were admitted/served in the following modalities: outpatient (637), housing support services (265), and residential substance abuse treatment (731 – duplicated) (data source: TARGET).

DBHR continued to exceed the base requirement for the maintenance of effort [U.S.C. 300x-22(b)(1)(C)] for the treatment of women, as well as other services to women. No new funds were available to expand or enhance the treatment capacity. The budget for FY 2008 for services to women (non-outpatient) was $14,620,123 and included:

PPW Residential (includes therapeutic childcare)	$ 8,705,810
Parent Child Assistance Program	$ 2,923 494
Safe Babies Safe Moms	$ 1,608,000
Fetal Alcohol Syndrome Family Resource Institute	$ 96,492
Fetal Alcohol Syndrome Information Srvs (Iceberg Newsletter)	$ 4,996
Fetal Alcohol Syndrome Diagnosis and Prevention Network	$ 354,050
PPW Housing Support Services (SAPT Block Grant Funds)	$ 777,269
Parent Trust	$ 100,008
Epic Crisis Nursery	$ 50,004
TOTAL	$14,620,123

SAPT Block Grant funds expended in adult residential treatment (non-PPW specific services) equaled $486,396 in FFY 2008, for women who were pregnant, had children in the home, or were involved with Child Protective Services. In FFY 2008, Housing Support Services utilized SAPT Block Grant funds of $631,081 (as identified in question #1 above), out of a total annual budget of $777,269. Outpatient treatment and support services utilized $545,764 (as identified in question #1 above) in FFY 2008. For FFY 2008, the total SAPT Block Grant funds expended specifically for pregnant and parenting women was $1,663,241 ($486,396 + $631,081 + $545,764), which equals 6.7% of the 1994 SAPT Block Grant funding ($24,807,591).

3. What special methods did the State use to **monitor** the adequacy of efforts to meet the special needs of pregnant women and women with dependent children?

DBHR has a program manager position designated to oversee and monitor its services for women. This program manager's responsibility included development of the specialized contracts for women's services; and overseeing their implementation, including tracking services and waiting lists. Additionally, the DBHR regional administrators monitored the county outpatient contracts. Regional Treatment Managers (RTMs) managed and monitored the review of residential programs in their respective region and conducted on-site reviews. Please see Goal 3 Activity 3.1 for an explanation of monitoring by the RTMs.

DBHR worked closely with the Washington State First Steps program to provide perinatal services to low-income women. Chemically involved pregnant women were one of the priority populations for First Steps, so together DBHR and First Steps worked to identify and meet the needs of these women. Outreach and case management were shared programs that monitored and provided feedback to DBHR on the adequacy of services to this population.

All contracted chemical dependency treatment providers reported to DBHR's TARGET management information system. This data provided information on the number of women assessed and treated by all of DBHR's contracted treatment programs, as well as those programs that provide specialized services for pregnant and postpartum women (housing support services). This data was coordinated with several other databases, including birth certificate records for infants born to the women. The results provided

DBHR with additional information on the needs of the women and the overall adequacy of services for women.

DBHR provided a staff liaison to the Women's Coalition of Washington. This coalition is comprised of direct service treatment providers and other individuals concerned about the treatment of women in Washington State. The coalition provided valuable information to DBHR on the adequacy of services to meet the needs of women.

4. What sources of data did the State use in estimating treatment capacity and utilization by pregnant women and women with dependent children?

Available funds dictated DBHR's overall treatment capacity for all clients, including women. Pregnant women intravenous drug users had highest priority for all treatment, followed by pregnant women. Parents with referrals from state Child Protective Services (CPS) received prioritized consideration. DBHR distributed funds among modalities of treatment (outpatient, intensive inpatient, or long term residential) based on the history of utilization, county needs assessments, reports by providers, assessment data, and provider collected/managed waiting lists.

All publicly funded facilities are required to report to the TARGET management information system. Data on treatment utilization was available from standard and special run TARGET reports. Utilization was monitored monthly by the Family Services Manager and funds were moved from one residential provider to another to ensure full utilization of services statewide.

5. What did the State do with FY 2008 Block Grant and/or State funds to establish new programs or expand the capacity of existing programs for pregnant women and women with dependent children?

In FFY 2008, $14,620,123 was budgeted (state funds and SAPT Block Grant funds) for pregnant and parenting women's programs. Please see question #2 for an explanation of dollars budgeted (does not include outpatient treatment services). DBHR continued to exceed the base requirement for the maintenance of effort for the treatment of women. No new funds were available to expand the capacity for treatment services.

DBHR expanded support services to pregnant and parenting women by adding two new Parent Child Assistance Programs (PCAP) (see attachment) in Clallam and Kitsap Counties. The sites began services July 1, 2008. The Clallam site has a capacity of 30 women ($163,128/year) and the Kitsap site has a capacity of 60 women ($291,648/year). Each site built capacity over time. General state funds were used for PCAP.

Childcare funds were distributed through the block grant to counties. Each county maintains a DBHR approved childcare plan for the utilization of their childcare funds that best meet the local needs of parents attending outpatient treatment. DBHR also continued its contracts for childcare directly with the specialized residential treatment programs for pregnant and postpartum women.

Goal #4: Services to intravenous drug abusers

An agreement to provide treatment to intravenous drug abusers that fulfills the 90 percent capacity reporting, 14-120 day performance requirement, interim services, outreach activities and monitoring requirements (See 42 U.S.C. §300x-23 and 45 C.F.R. §96.126).

Note: In addressing this narrative the State may want to discuss activities or initiatives related to the provision of: *Interim services; Outreach Waiting list(s); Referrals; Methadone maintenance; Compliance reviews; HIV/AIDS testing/education; Outpatient services; Education; Risk reduction; Residential services; Detoxification; and Assessments.*

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

Goal #4 Intravenous Drug Users
FY 2011-2013 Intended Use

Activity 4-1:
DBHR contracts will continue to have language to ensure that treatment is provided to intravenous drug abusers. Providers will be expected to fulfill requirements related to the 90 percent capacity, 14-120 day admission, interim services, outreach activities, and monitoring requirements.

Contract language will continue to read:

a. Treatment for Injecting Drug Users (IDUs):

The Contractor shall ensure all treatment programs for chemical dependency establish admission priorities for IDUs. The Contractor or its subcontractors shall notify DBHR in writing if they fall below 90 percent of their capacity to admit IDUs to their program.

The Contractor shall:

(1) Ensure chemical dependency assessment and treatment services shall be provided to IDUs no later than 14 days after the service has been requested by the individual. If the individual cannot be placed in treatment within 14 days, interim services must be made available to the individual.
(2) Include the IDU form as part of their State annual reporting process. The IDU form shall report the number of people currently receiving IDU interim services.

b. Outreach for IDUs Required:
The Contractor shall ensure that it provides IDU outreach activities for all programs treating IDUs and receiving federal block grant funds. These outreach activities shall be specifically designed to reduce transmission of Human Immunodeficiency Virus (HIV) disease and encourage IDUs to undergo treatment.

(1) Programs may use street outreach activities as well as more formal education and risk-reduction counseling at the treatment site.
(2) Specific service levels and funds budgeted under this Agreement for IDU outreach activities shall be designated in the SRP. If IDU outreach activities are provided from a documented source of revenue outside of this Agreement, then these service levels and funds are not designated in the SP.
(3) The Contractor may opt to provide these activities:
    (a) Through one subcontractor who works in close collaboration with all treatment providers providing treatment to IDUs; or
    (b) Require all IDU treatment providers to provide the outreach services

All contracts will have at least one on-site review during the 2-year contract period by a DBHR Contractor Manager. County contractors will be responsible to monitor and provide technical assistance to subcontractors within their respective counties and provide a report to DBHR.

Many facilities are typically at full capacity; therefore, notification to DBHR will continue to be necessary only when treatment capacity falls below 90 percent. At the end of the fiscal year, county contractors are to provide to DBHR information on regarding all IDU services provided by their subcontractors to include: How many subcontractors are below 90% capacity, a description of how counties ensure subcontractor's compliance to this requirement, and what activities or initiatives are in place to ensure IVDUs receive treatment, referrals, or interim services.

Goal 4 – Intravenous Drug Users
FFY 2008 Compliance

There were approximately 375 publically-funded treatment providers in the state which include residential, outpatient, and detoxification programs. No provides had services specifically targeting intravenous drug users (IVDU). However, providers who receive SAPT funding were required by contract to assure that IVDU clients were considered a priority population and as such be given priority admission. If treatment was not available then interim services would be provided until such time that the IVDU client could be admitted.

Many of the publically-funded treatment providers were at or near full capacity and had wait lists. Assessment appointments generally required a two week wait followed by an admission wait time of two weeks to a month. Because of these constantly high utilization levels, the Division of Behavioral Health and Recovery (DBHR) chose to require providers to report when they fell below the 90 percent capacity level instead of when they reached 90% capacity. In FFY 2008, no provider fell below 90% capacity.

Our data management system indicated that in FFY2008, 6,998 IVDU clients were receiving treatment services; 55% were male; approximately, 82% were Caucasian; African Americans represented the highest minority group at 6%; four percent 4% were pregnant or parenting women.

Counties were also required to report annually the number of IVDU priority admissions and any outreach and/or interim services provided. According to county annual reports, approximately 2024 IVDU clients received assessments, with 1740 being admitted for treatment, 30 were placed on a waiting list, and 250 hours of interim services were provided. IVDU clients received over 57,115 hours of treatment services once admitted.

Many IVDU clients were assessed were referred to inpatient treatment. If they were appropriate for outpatient, they were admitted to services immediately. These individuals often required more case management time to coordinate with other service providers, assist with applications for benefits, etc. Some treatment providers did extensive outreach in the community by participating in a multi-disciplinary staffing with a team of agencies in the county, offering training, coordinating with the health department, the needle exchange program, and other community events. **No SAPT funds were used to support needle-exchange.**

DBHR Contract Managers managed outpatient, residential, youth or PPW contracts in their region as well as conducted on-site monitoring of each treatment contracts at least once during the 2-year contract period. Monitoring protocols were followed, completed, and placed in the contract file. A corrective action plan was established if there were any findings identified. Counties, who subcontracted for outpatient services, conducted on-site monitoring of each of their subcontractors and reported to DBHR any findings and corrective plans. For FY2008, there were no findings noted by either the DBHR contract managers or county contractors.

Goal #4 Intravenous Drug Users
FY 2010 Progress

For FFY 2010 through July 2010, there are approximately 375 publically-funded treatment providers which include residential, outpatient, and detoxification programs. None of these providers have services specifically targeting intravenous drug users (IVDU). However, providers who receive SAPT funding are required by contract to assure that IVDU clients are considered a priority population and as such be given priority admission. If treatment is not available then interim services are provided until such time that the IVDU client can be admitted.

Many of the publically-funded treatment providers are at or near full capacity. Because of these constantly high utilization levels, the Division of Behavioral Health and Recovery (DBHR) require providers to report when they fall below the 90 percent capacity level instead of when they reached 90% capacity. No provider has fallen below 90% capacity to date.

DBHR includes language in outpatient contracts to ensure that treatment is provided to intravenous drug abusers. Providers are expected to fulfill requirements related to the 90 percent capacity, 14-120 day admission, interim services, outreach activities, and monitoring activities.

The contract language reads:

a. Treatment for Injecting Drug Users (IDUs):

The County shall ensure all treatment programs for chemical dependency establish admission priorities for IDUs. The County or its subcontractors shall notify DASA in writing if they fall below 90 percent of their capacity to admit IDUs to their program.

The County shall:

(1) Ensure chemical dependency assessment and treatment services shall be provided to IDUs no later than 14 days after the service has been requested by the individual. If the individual cannot be placed in treatment within 14 days, interim services as defined in the DCIG, must be made available to the individual.
(2) Include the DASA provided IDU form as part of their State annual reporting process to ensure that Counties are monitoring their programs regarding IDU interim services. The IDU form shall report the number of people currently receiving IDU interim services.

b. Outreach for IDUs Required:

The County shall ensure that it provides IDU outreach activities for all programs treating IDUs and receiving federal block grant funds. These outreach activities shall be specifically designed to reduce transmission of Human Immunodeficiency Virus (HIV) disease and encourage IDUs to undergo treatment.

(1) Programs may use street outreach activities as well as more formal education and risk-reduction counseling at the treatment site.
(2) Specific service levels and funds budgeted under this Agreement for IDU outreach activities shall be designated in the SRP. If IDU outreach activities are provided from a documented source of revenue outside of this Agreement, then these service levels and funds are not designated in the SP.
(3) The County may opt to provide these activities:
    (a) Through one subcontractor who works in close collaboration with all treatment providers providing treatment to IDUs; or
    (b) Require all IDU treatment providers to provide the outreach services

Our data management system indicates that from FFY 2008 to July 31, 2010, 6919 IVDU clients have receive treatment services; 55% were male; 82% were Caucasian; African Americans represented the highest minority group at 6%; and, 4% were pregnant or parenting women. There were 105 IVDU clients who have received interim services

DBHR Contract Managers manage outpatient, residential, youth or PPW contract in their region as well as conduct on-site monitoring of each treatment contract at least once during the contract period. Monitoring protocols are followed, completed, and placed in the contract file. A corrective action plan is established if there are any findings identified. Counties, who subcontract for outpatient services, conduct on-site monitoring of each of their subcontractors and report any findings and corrective plans. For SFY2010, approximately 50% of the contractors have been reviewed and there were no findings noted by either the DBHR contract managers or county contractors.

Programs for Intravenous Drug Users (IVDUs) (formerly Attachment C)

See 42 U.S.C. §300x-23; 45 C.F.R. §96.126; and 45 C.F.R. §96.122(f)(1)(ix))

For the fiscal year three years prior (FY 2008; Annual Report/Compliance) to the fiscal year for which the State is applying for funds:

1. How did the State define IVDUs in need of treatment services?

2. 42 U.S.C. §300x-23(a)(1) requires that any program receiving amounts from the grant to provide treatment for intravenous drug abuse notify the State when the program has reached 90 percent of its capacity. Describe how the State ensured that this was done. Please provide a list of all such programs that notified the State during FY 2008 and include the program's I-SATS ID number (See 45 C.F.R. §96.126(a)).

3. 42 U.S.C. §300x-23(a)(2)(A)(B) requires that an individual who requests and is in need of treatment for intravenous drug abuse is admitted to a program of such treatment within 14-120 days. Describe how the State ensured that such programs were in compliance with the 14-120 day performance requirement (See 45 C.F.R. §96.126(b)).

4. 42 U.S.C. §300x-23(b) requires any program receiving amounts from the grant to provide treatment for intravenous drug abuse to carry out activities to encourage individuals in need of such treatment to undergo treatment. Describe how the State ensured that outreach activities directed toward IVDUs was accomplished (See 45 C.F.R. §96.126(e)).

Programs for Intravenous Drug Users (IVDUs)

1. How did the State define IVDUs in need of treatment services?

DBHR defines IVDUs as individuals who self report using syringes (needles) for administering illicit substances.

2. 42 U.S.C. 300x-23(a)(1) requires that any program receiving amounts from the grant to provide treatment for intravenous drug abuse notify the State when the program has reached 90 percent of its capacity. Describe how the State ensured that this was done. Please provide a list of all such programs that notified the State during FY 2008 and include the program's I-SATS ID number (See 45 C.F.R. 96.126(a)).

Most facilities are typically near full capacity so instead of notifying the Division of Behavioral Health and Recovery (DBHR) when they reach 90% capacity; providers were required by contract to report when they fall below 90 percent capacity. No providers fell below the 90% capacity.

3. 42 U.S.C. 300x-23(a)(2)(A)(B) requires that an individual who requests and is in need of treatment for intravenous drug abuse is admitted to a program of such treatment within 14-120 days. Describe how the State ensured that such programs were in compliance with the 14-120 day performance requirement (See 45 C.F.R. 96.126(b)).

DBHR contracts included the following language:

> The County shall:
>
> Ensure chemical dependency assessment and treatment services shall be provided to IDUs no later than 14 days after the service has been requested by the individual. If the individual cannot be placed in treatment within 14 days, interim services as defined in the DCIG, must be made available to the individual.

Beginning December 2009, providers were required to enter information regarding "Date of First Contact". DBHR Regional Teams are now able to monitor when clients request treatment, receive treatment, if interim services were provided, and what those interim services were.

4. 42 U.S.C. 300x-23(b) requires any program receiving amounts from the grant to provide treatment for intravenous drug abuse to carry out activities to encourage individuals in need of such treatment to undergo treatment. Describe how the State ensured that outreach activities directed toward IVDUs was accomplished (See 45 C.F.R. 96.126(e)).

DBHR includes the following language regarding outreach in all County Community Services contracts:

> The County shall ensure that it provides IDU outreach activities for all programs treating IDUs and receiving federal block grant funds. These outreach activities shall be specifically designed to reduce transmission of Human Immunodeficiency Virus (HIV) disease and encourage IDUs to undergo treatment.

Programs may use street outreach activities as well as more formal education and risk-reduction counseling at the treatment site.

Specific service levels and funds budgeted under this Agreement for IDU outreach activities shall be designated in the spending plan. If IDU outreach activities are provided from a documented source of revenue outside of this Agreement, then these service levels and funds are not designated in the Spending Plan.

The County may opt to provide these activities:

(a)Through one subcontractor who works in close collaboration with all treatment providers providing treatment to IDUs; or

(b) Require all IDU treatment providers to provide the outreach services.

Program Compliance Monitoring (formerly Attachment D)

(See 45 C.F.R. §96.122(f)(3)(vii))

The Interim Final Rule (45 C.F.R. Part 96) requires effective strategies for monitoring programs' compliance with the following sections of Title XIX, Part B, Subpart II of the PHS Act: 42 U.S.C. §300x-23(a); 42 U.S.C. §300x-24(a); and 42 U.S.C. §300x-27(b).

For the fiscal year two years prior (FY 2009) to the fiscal year for which the State is applying for funds:

In **up to three pages** provide the following:

• A description of the strategies developed by the State for monitoring compliance with each of the sections identified below; and

• A description of the problems identified and corrective actions taken:

1. **Notification of Reaching Capacity** 42 U.S.C. §300x-23(a)
(See 45 C.F.R. §96.126(f) and 45 C.F.R. §96.122(f)(3)(vii));
2. **Tuberculosis Services** 42 U.S.C. 300x-24(a)
(See 45 C.F.R. §96.127(b) and 45 C.F.R. §96.122(f)(3)(vii)); and
3. **Treatment Services for Pregnant Women** 42 U.S.C. §300x-27(b)
(See 45 C.F.R. §96.131(f) and 45 C.F.R. §96.122(f)(3)(vii)).

This narrative response not included because it does not exist or has not yet been submitted. Please submit a request to the BGAS helpdesk for further inquiry.

Goal #5: TB Services

An agreement, directly or through arrangements with other public or nonprofit private entities, to routinely make available tuberculosis services to each individual receiving treatment for substance abuse and to monitor such service delivery (See 42 U.S.C. §300x-24(a) and 45 C.F.R. §96.127).

Note: In addressing this narrative the State may want to discuss activities or initiatives related to the provision of: *Compliance monitoring: Referrals; Screening; PPD or Mantoux Skin tests; Provider contracts; Site visits/reviews; Assessments; Counseling; Training/TA; Cooperative agreements; Case management; Wait lists; Promotional materials*

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

Goal #5 –Tuberculosis services
FFY2011-13 (Intended Use)

Activity 5.1:

DBHR, through Washington Administrative Code (WAC) 388-805, will continue to require all certified chemical dependency service providers (certified agencies) to perform TB screening and referral to local health departments or other health care providers for testing, treatment, and follow-up services. TB requirements in WAC 388-805 are found in Sections 200(4)(b), 300(8)(ac), and 325(9) at: http://apps.leg.wa.gov/wac/default.aspx?cite=388-805. Chemical dependency service providers (certified agencies) will also be required to implement TB control as directed by the Washington State Department of Health.

All chemical dependency service providers (agencies) certified by the Division of Behavioral Health and Recovery (DBHR) will be required to comply with certification requirements including language mandating tuberculosis (TB) services be available to every patient receiving treatment for substance abuse regardless of funding source.

TB services will include counseling the individual with respect to tuberculosis, screening to determine whether the individual has been infected with mycobacteria tuberculosis to determine the appropriate referral for treatment of the individual, and providing or referring patients infected by mycobacteria tuberculosis for appropriate medical evaluation and treatment.

DBHR Certification staff will continue its TB monitoring activities by completing individual agency on-site technical assistance surveys. DBHR Certification staff members will complete about 175 on-site surveys during each FFY.

During each on-site survey, DBHR Certification Specialists will use extensive checklists conducting patient record reviews which will include compliance with the TB requirements of WAC 388-805, Section 200(4)(b), 300(8)(a-c), and 325(9). Certification Specialists will review each patient record for documentation of TB screening, TB skin tests, and appropriate referrals.

Certification Specialists will complete on-site survey reports that list each deficiency, request corrective action plans from certified agencies, and conduct follow-up on-site surveys to ensure implementation of corrective action.

Activity 5-2
During FFY 2011-2013, DBHR Certification Specialists will support and help certified agencies to implement the *Tuberculosis Infection Control Program: Model Policies for Chemical Dependency Treatment Agencies in Washington State*. DBHR staff members will provide technical assistance to individual agencies that revise their policies and procedures and begin completing annual TB infection control risk assessments of their health care settings. The revised model policies, *Tuberculosis Infection Control Program: Model Policies for Chemical Dependency Treatment Agencies in Washington State* are located at: http://www.dshs.wa.gov/DBHR/services/certification/Main/agencycertification.shtml.

DBHR will also schedule and present its revised *Tuberculosis Infection Control Program: Model Policies for Chemical Dependency Treatment Agencies in Washington State* to state-certified chemical dependency treatment agencies and professional chemical dependency associations.

Goal #5 –Tuberculosis services
FFY 2008 (Compliance)

All chemical dependency service providers (agencies) certified by the Division of Behavioral Health and Recovery (DBHR) were required to comply with certification requirements including language mandating tuberculosis (TB) services be available to every patient receiving treatment for substance abuse regardless of funding source.

TB services included counseling with respect to tuberculosis, screening to determine whether the individual has been infected with mycobacteria tuberculosis to determine the appropriate referral for treatment, and provided or referred patients infected by mycobacteria tuberculosis for appropriate medical evaluation and treatment.

DBHR, through Washington Administrative Code (WAC) 388-805, required all certified chemical dependency service providers (certified agencies) to perform TB screening and referral to local health departments or other health care providers for testing, treatment, and follow-up services. TB requirements in WAC 388-805 are found in Sections 200(4)(b), 300(8)(a-c), and 325(9) at: http://apps.leg.wa.gov/wac/default.aspx?cite=388-805. Chemical dependency service providers (certified agencies) were also required to implement TB control as provided by the Washington State Department of Health.

During FFY 2008, the DBHR Certification staff continued its on-going TB monitoring activities by completing individual agency on-site and technical assistance surveys in calendar years 2007/08. The total number of state-certified programs on September 30, 2008, was 577. By September 30, 2008, the DBHR Certification staff had completed about 175 (137 routine and 38 corrective action plan implementation) on-site and technical assistance surveys during the year.

During each on-site survey, DBHR Certification Specialists used extensive checklists while conducting patient record reviews to assess compliance with the TB requirements of WAC 388-805, Section 200(4)(b), 300(8)(a-c), and 325(9). Certification Specialists specifically looked at each patient record reviewed during the on-site survey for documentation of TB screening, TB skin tests, and appropriate referrals. Certification Specialists complete on-site survey reports that list each deficiency, requested corrective action plans from certified agencies (if necessary), and conducted follow-up on-site surveys to ensure implementation of corrective action.

During FFY 2008, DBHR continued to publish the model policies, *Tuberculosis Infection Control Program: Model Policies for Chemical Dependency Treatment Agencies in Washington State* located at: http://www.dshs.wa.gov/DBHR/services/certification/Main/agencycertification.shtml.

Goal #5 – Tuberculosis services
FFY2010 (Progress)

All chemical dependency service providers (agencies) certified by the Division of Behavioral Health and Recovery (DBHR) are required to comply with certification requirements including language mandating tuberculosis (TB) services be available to every patient receiving treatment for substance abuse regardless of funding source.

TB services include counseling with respect to tuberculosis, screening to determine whether the individual has been infected with mycobacteria tuberculosis to determine the appropriate referral for treatment, and provide or refer patients infected by mycobacteria tuberculosis for appropriate medical evaluation and treatment.

DBHR, through Washington Administrative Code (WAC) 388-805, continues to require all certified chemical dependency service providers (certified agencies) to perform TB screening and referral to local health departments or other health care providers for testing, treatment, and follow-up services. TB requirements in WAC 388-805 are found in Sections 200(4)(b), 300(8)(ac), and 325(9) at: http://apps.leg.wa.gov/wac/default.aspx?cite=388-805. Chemical dependency service providers (certified agencies) are required to implement TB control as provided by the Washington State Department of Health.

In addition, DBHR has included the following language in all contracts:

> **28, Tuberculosis Services,** per CFR 45 96.121, 96.127 and WAC 388-805 tuberculosis services shall include but are not limited to:
>
> a. Counseling the individual with respect to tuberculosis.
> b. Screening to determine whether the individual has been infected with mycobacteria tuberculosis to determine the appropriate referral for treatment of the individual.
> c. Providing or referring the individuals infected by mycobacteria tuberculosis for appropriate medical evaluation and treatment.

During FFY 2010, the DBHR Certification staff is continuing its TB monitoring activities by completing individual agency on-site technical assistance surveys. DBHR Certification staff has completed 80 on-site surveys from October 1, 2009, through August 31, 2010. We anticipate completing another 70 on-site surveys for a total of about 150 on-site surveys by the close of FFY 2010.

During each on-site survey, DBHR Certification Specialists use extensive checklists while conducting patient record reviews which include compliance with the TB requirements of WAC 388-805, Section 200(4)(b), 300(8)(a-c), and 325(9). Certification Specialists review each patient record for documentation of TB screening, TB skin tests, and appropriate referrals. Certification Specialists complete an on-site survey report that list each deficiency, requests a corrective action plan, and conduct follow-up on-site surveys to ensure implementation of corrective action.

During FFY 2010, DBHR Certification Specialists have supported and helped certified-agencies implement the *Tuberculosis Infection Control Program: Model Policies for Chemical Dependency Treatment Agencies in Washington State*. DBHR staff provides technical assistance to individual agencies to revise their policies and procedures and begin completing annual TB infection control risk assessments of their health care settings. The revised model policies, *Tuberculosis Infection Control Program: Model Policies for Chemical Dependency Treatment Agencies in Washington State* are located at: http://www.dshs.wa.gov/DBHR/services/certification/Main/agencycertification.shtml.

DBHR presented its revised *Tuberculosis Infection Control Program: Model Policies for Chemical Dependency Treatment Agencies in Washington State* to a number of professional chemical dependency associations including:

- Association of County Human Services
- Association of Alcoholism and Addiction Programs
- Washington State Association of Independent Outpatient Programs

Goal #6: HIV Services

An agreement, by designated States, to provide treatment for persons with substance abuse problems with an emphasis on making available within existing programs early intervention services for HIV in areas of the State that have the greatest need for such services and to monitor such service delivery (See 42 U.S.C. §300x-24(b) and 45 C.F.R. §96.128).

Note: If the State is or was for the reporting periods listed a designated State, in addressing this narrative the State may want to discuss activities or initiatives related to the provision of: *HIV testing; Counseling; Provider contracts; Training/TA Education; Screening/assessment; Site visits/reviews; Rapid HIV testing; Referral; Case management; Risk reduction; and HIV-related data collection*

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

Washington State is not a designated HIV state.

Washington State is not a designated HIV state.

Washington State is not a designated HIV state.

Tuberculosis (TB) and Early Intervention Services for HIV (formerly Attachment E)

(See 45 C.F.R. §96.122(f)(1)(x))

For the fiscal year three years prior (FY 2008; Annual Report/Compliance) to the fiscal year for which the State is applying for funds:

Provide a description of the State's procedures and activities and the total funds expended for tuberculosis services. If a "designated State," provide funds expended for early intervention services for HIV. Please refer to the FY 2008 Uniform Application, Section III.4, FY 2008 Intended Use Plan (Form 11), and Appendix A, List of HIV Designated States, to confirm applicable percentage and required amount of SAPT Block Grant funds expended for early intervention services for HIV.

Examples of **procedures** include, but are not limited to:

• development of procedures (and any subsequent amendments), for tuberculosis services and, if a designated State, early intervention services for HIV, e.g., Qualified Services Organization Agreements (QSOA) and Memoranda of Understanding (MOU);
• the role of the Single State Agency (SSA) for substance abuse prevention and treatment; and
• the role of the Single State Agency for public health and communicable diseases.

Examples of **activities** include, but are not limited to:

• the type and amount of training made available to providers to ensure that tuberculosis services are routinely made available to each individual receiving treatment for substance abuse;
• the number and geographic locations (include sub-State planning area) of projects delivering early intervention services for HIV;
• the linkages between IVDU outreach (See 42 U.S.C. §300x-23(b) and 45 C.F.R. §96.126(e)) and the projects delivering early intervention services for HIV; and
• technical assistance.

TB and Early Intervention Services for HIV

The Division of Behavioral Health and Recovery (DBHR) requires all DBHR-certified alcohol and drug treatment programs to establish policies, procedures, and protocols for control and prevention of Tuberculosis (TB). TB services must include counseling the individual with respect to tuberculosis, screening to determine whether the individual has been infected with mycobacteria tuberculosis to determine the appropriate referral for treatment of the individual, and providing or referring patients infected by mycobacteria tuberculosis for appropriate medical evaluation and treatment.

DBHR worked with the Washington State Department of Health (DOH)* who funds the majority of TB services in the state to ensure certified treatment agencies provide TB services in the most comprehensive and cost-effective manner. The DOH TB Program is responsible for the prevention, control and coordination of TB within Washington State. Program components include:

- Technical assistance and health education to local health departments, health professionals, and communities.
- Medical consultation (TB Consultation Form) (PDF, 19 KB).
- Disease and laboratory surveillance.
- Assistance with contact investigations.

DOH and local health districts within each region provide oversight of TB prevention and education within their jurisdictions. Local health district's, funded in part by DOH, work collaboratively with certified treatment agencies to provide TB services. In SFY 2008, the county health jurisdictions spent $9,430,272 (state funds only) on TB education, screening, testing, and referral for treatment. DOH reports that the incidence of TB in Washington State in FY2008 decreased to 3.5 per 100,000, down from 4.5 per 100,000 the year before. Revenue summaries for SFY 2009 or SFY 2010 have not yet been published. DOH also reported that the incidence of TB in Washington State in 2009 had increased to 3.8 per 100,000, up from 3.5 per 100,000 the year before. DBHR monitors DOH and local health district expenditures for TB prevention and control and the incidence of TB in Washington State by accessing annual reports and meeting during the year with program members of the DOH TB Program to discuss prevention and control activities. Annual reports are located at:

- World TB Day 2010 Fact Sheet located at: http://www.doh.wa.gov/cfh/TB/default.htm.
- Revenue Summary Funding of Local Health Jurisdictions - 2008, Statewide Summary by Expenditure Code at: http://www.doh.wa.gov/a-z_topics/r.htm.

As such the Hepatitis AIDS Substance Abuse Program (HASAP) has enhanced treatment services for Hepatitis C and HIV positive substance abusing clients statewide. HASAP has out stationed Chemical Dependency Professionals in HIV housing or Health Department facilities to provide assessments, case management and counseling services. Technical assistance is also provided to the treatment service providers regarding integration of service delivery models, such as the evidenced based program Holistic Health Recovery Program (HHRP) which was implemented in 2008/2009 within the 6 HASAP programs statewide. Previously, trainings were provided for HIV rapid testing and the Diffusion of Effective Behavioral Intervention (DEBI) for HIV positive substance abusers in treatment settings named HHRP.
*The DOH TB Program is located at: http://www.doh.wa.gov/cfh/TB/default.htm.

The mission of the TB Program is to help provide a healthier environment in Washington State by reducing or eliminating TB through identification of TB cases and detection and prevention of TB infection. Priorities include:

- Diagnosis and treatment of disease.
- Access to TB screening; identification of groups at high risk for TB.
- Monitoring adherence to and completion of treatment.
- TB laboratory activities.
- Implementing community partnerships in the efforts against tuberculosis.

Goal #7: Development of Group Homes

An agreement to continue to provide for and encourage the development of group homes for recovering substance abusers through the operation of a revolving loan fund (See 42 U.S.C. §300x-25). Effective FY 2001, the States may choose to maintain such a fund. If a State chooses to participate, reporting is required.

Note: If this goal is no longer applicable because the project was discontinued, please indicate.

If the loan fund is continuing to be used, please indicate and discuss distribution of loan applications; training/TA to group homes; loan payment collections; Opening of new properties; Loans paid off in full; and loans identified as in default.

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

Goal 7 - Group Home Entities and Programs
FFY2011 – 2013 (Intended Use)

Three Year Plan for 2011 through 2013:
Over the next three years, The Division of Behavioral Health and Recovery (DBHR) will support Oxford House, Inc. to open an additional eight houses per year to provide an additional 144 to 216 recovery beds. These additional houses will create a network of recovery housing support that provides more than 2,000 beds and one that spans 71,302 square miles statewide. For existing and additional houses, per contract, Oxford House staff will provide essential residential support services, such as: coordinate outreach to associated treatment providers, drug courts, 12-Step groups and other community supports. Furthermore, Oxford House will continue to maintain the level of high quality service, including 24-hour on-call services, which has been provided over the past 18 years.

Target Population:
The target population for Oxford House, Inc. will be individuals who are in recovery from alcoholism and/or drug abuse and who can benefit from living in an alcohol- and drug-free environment that is supportive of long-term sobriety. Priority will be given to individuals who are in the early process of recovery and leaving treatment with no place to go. These individuals will be evaluated during treatment and assisted, but any recipient of detoxification and/or treatment shall be given the same consideration if the alcohol- and drug-free living environment of an Oxford House will provide an opportunity to achieve sobriety without relapse.

We estimate that the number of patients to be served is increasing according to the DASA Treatment Expansion: Spring 2009 Update: *Expanding access to alcohol/drug treatment*. Significant medical cost savings as a result of providing treatment have been realized. Estimated total medical cost savings in Federal Fiscal Year (FFY) 2008 was $16.8 million, including $14.5 million for Medicaid Disabled Adult patients and $2.3 million for General Assistance Unemployable (GA-U) now called Disability Lifeline (DL) patients. These estimates include the ongoing impact of increases in substance abuse treatment penetration that began in Federal Fiscal Year 2005. It states that for the Treatment Expansion target populations, the number of patients served increased from a baseline of 18,378 in Federal Fiscal Year 2005 to 23,791 in Federal Fiscal Year 2008, representing a 29.5 percent increase. Many adults need substance abuse services each year, but the state's public system only will serve a small percentage of those in need in State Fiscal Years 2011 through 2013. The inability to obtain and sustain safe and affordable housing is one of the most significant barriers facing persons in the early stages of recovery. Oxford House, Inc. fills this need in a low-cost and effective manner. As of December 31, 2009, military veterans made-up 18 percent of Oxford House population, and at least six men were veterans of the Iraq war. Although Oxford House now has 220 houses in 47 cities in Washington State that can serve more than 1,900 individuals, the demand for additional Oxford House units remains.

Program Goals and Objectives:
The primary measurable results of this contract will be the opening of eight additional Oxford Houses per year to provide at 144 to 216 beds or units of housing. To implement this goal successfully in the state of Washington, Oxford House will attain the following goals and objectives:
Goal 1.0 – Manage a Revolving Loan Fund to assist persons recovering from substance abuse to reside in the time-tested Oxford House environment that will help them maintain sobriety and achieve stability in their lives.
Objective 1.1 – By June 30, 2013, make 24 $4,000.00 loans to establish 24 new Oxford Houses that will serve 144 - 216 persons recovering from substance abuse.

Goal 2.0 – Maintain a statewide system for managing Oxford House, Inc., group recovery homes that will assist persons recovering from substance abuse to maintain sobriety and achieve stability in their lives.

Objective 2.1 – Oxford House will oversee six Outreach Workers whose primary duties will be to assist in the establishment, management, and oversight of the group recovery homes as outlined in Table 1 below.

Table 1: Outreach Workers' Activities

Task	Action of Outreach Worker
1. Finding a suitable house.	♦ The Outreach Workers have been trained to recognize the characteristics of a suitable house to rent. ♦ The Outreach Workers know how to execute a legal lease between the landlord and the group or entity that is made-up of ever changing residents. ♦ The Outreach Worker is able to answer zoning questions – in a general way – and is backed up by the expertise of the central service office in Silver Spring.
2. Obtaining a charter from Oxford House, Inc.	♦ Outreach Worker will help newly recovering individuals to fill out the charter application form and submit it to Oxford House, Inc. to get a "conditional" charter that is valid for up to six months. ♦ Outreach Worker will help the new group to fulfill the requirements of the "conditional" charter so that the group can be granted a "permanent" charter.
3. Obtaining an FEIN (federal tax identification number) from IRS to enable the group to establish a checking account in the name of the group.	♦ The Outreach Worker will process the paperwork to obtain a FEIN and help the group to establish a checking account in the name of the individual Oxford House.
4. Recruiting initial residents for the new house.	♦ Working with treatment providers, jails, prisons, drug courts, and the recovery community to explain the value of Oxford House living to get referrals. ♦ Convincing a newly recovering individual that living in an Oxford House provides the time, peer support, and living environment to gain comfortable sobriety without relapse.
5. Teaching residents in a newly established Oxford House the standard system of operations needed to effectively operate the house.	♦ Teaching new residents the need for a weekly business meeting and the procedures to follow. ♦ Helping the residents elect the five essential officers needed to operate each house and teaching each person the duties of each office. ♦ Helping the residents get the household furnishings needed for the house (from beds to brooms). ♦ Story telling while living in the house to infuse the group with the belief and culture of Oxford House and its role in promoting recovery without relapse.
6. Instilling a dedication to reach out to other recovering individuals to share the benefits of Oxford House living.	♦ Teaching residents how to make presentations to providers and those interested to get new recruits. ♦ Promotion of expansion within an area to meet the needs of newly recovering individuals and to organize a mutually supportive chapter.

	♦ Building a habit of attending 12-Step meetings and the encouragement of frequent contact between residents and Oxford House World Services to resolve house issues, promote expansion, and to become an active participant in on-going expansion.

Objective 2.2 – Oxford House will maintain a web-based listing, including: the name, address, telephone number, e-mail address, and contact person's name for all of its pre-existing and new recovery homes in Washington State.

Objective 2.3 – Oxford House will inform DBHR, treatment providers, veteran's hospitals, correction systems, drug courts, and community-based and faith-based organizations of the availability of the web-based listing of recovery homes.

Objective 2.4 – Oxford House will continue to create and maintain an information exchange that includes DBHR, treatment providers, city jails, federal prisons, the court system, veteran's hospitals, veteran's groups, and homeless shelters to match recovering individuals seeking group home residences with vacancies in houses located in areas convenient for the clients.

Objective 2.5 – Oxford House will disseminate information on the concept of group recovery homes at professional meetings, conferences, newsletters, and journals.

Objective 2.6 – Oxford House Outreach Workers will participate in self-help group meetings, retreats and other gatherings and meetings of providers and provider groups and workshops to distribute leaflets and brochures and spread the word-of-mouth message about the concept of group recovery homes.

Objective 2.7 – Oxford House Regional Outreach Manager will make bi-monthly scheduled visits and at least one unannounced visit per year to each existing and new home to determine their level of compliance to federal and local governmental rules and Oxford House policies and procedures.

For a complete list of Washington State houses, populations served, and availability go to: http://www.dshs.wa.gov/pdf/hrsa/dasa/Directory/APPNDXH.pdf

Development of New Client Oxford Houses:
Oxford House shall develop, at a minimum, 24 new client-based Oxford Houses by June 30, 2013 (8 per year). The sites shall be determined based upon need across the state, with the final decision requiring the consent of the DBHR Contract Manager.

Reporting Requirements:
Through contract with DBHR, the Oxford House shall:

a. Prepare a monthly Oxford House Development Progress Report on the status of the homes in operation and in planning stages to the DBHR Contract Manager. The reports shall include: statistics on the program's performance, expenditure reports, and narratives describing overall progress.
b. Respond to requests for corrective actions determined on the basis of any or all plans, reports, or evaluations. The contract shall be evaluated at the end of the contract period to consider continuation.

Evaluation Plan:
For the evaluation report to DBHR, the Oxford House will use internal and external indicators to monitor how efficiently and effectively it implements its work plan. Oxford staff will submit monthly Housing

Activity Reports that include data from each new and existing house regarding the number of applications, number of houses opened (including gender), number of houses closed (including gender), number of beds available, number of admissions, and number of residents leaving the houses and the reasons for leaving: relapse, voluntary, or other causes such as disruptive behavior. This data provides valuable information on the provision of care and functioning in each individual home.

Another report that provides valuable information on evaluating Oxford House is the Annual Resident Profile Survey. This is a yearly survey completed by all residents residing in Oxford Houses. This data is compiled by the Oxford House Director of Operations and used to generate a profile of Washington State Oxford House residents. Resident race and ethnicity, disability status, prior homelessness, prior incarceration (individuals just released as a part of the Criminal Justice Initiative as well as individuals incarcerated in the past), average length of sobriety, and average monthly earnings are contained on the survey. The primary outcome measure for this project is for Oxford House to implement operations for eight new Oxford Houses annually. In addition to this outcome measure, Table 2 summarizes additional outcomes and the service quality measures that will be gleaned from the Monthly Housing Activity Report and Annual Resident Profile Survey.

Table 2 – Oxford House Outcome Measures

Project Report	Outcome Measure
Monthly Housing Activity Report	Average annual occupancy rate from the sum of monthly housing reports will be at least 80 percent.
	Average annual relapse rate (total number residents that relapse/total number residents) from the sum of monthly housing reports will be no higher than 10 percent.
Annual Resident Profile Survey	Average length of sobriety for residents will be greater than 12 months.
	Employment rate for residents will be at least 75 percent.
	Average number of 12-Step meetings that each resident attends per week will be at least 5.
	At least 75 percent of residents surveyed will say that Oxford House is "very important to sobriety."
	At least 75 percent of residents surveyed will say they would recommend Oxford House to other persons with substance abuse issues.

In addition to indicators of operational performance, the national Oxford House staff managing this loan will provide the state with the following reports:

- Monthly Financial Status Report, and
- Annual Financial Audit.

Goal 7 Group Home Entities and Programs
FY 2010 Compliance

In FY 2008, DBHR maintained two contracts with Oxford House Inc., the Revolving Fund, and Client Services; one coordinated the start-up loans for new houses and the second funded outreach workers wages and benefits.

These Oxford Houses served individuals in recovery from alcohol and drug addiction. The individuals who resided in these homes came from a number of service delivery systems such as intensive inpatient treatment, jails, treatment centers, and other points in the Treatment Community. Oxford houses provided the opportunity to learn life and living skills to better manage behavioral health issues and improve social skills while in the early phases of recovery.

DBHR developed 24 new Oxford Houses in locations throughout the state in 2008. These new houses included fourteen new houses for men, six new houses for women, and four new houses for women with children. The total number of Oxford houses in the state during the indicated timeframe was 194. The statewide bed capacity per day was 1,552.

The majority of the Oxford Houses are located in Western Washington along the Interstate 5 Corridor from the Canadian border to the Oregon State line. There are five houses located in Eastern Washington.

The 195 Oxford Houses in the State of Washington are gender specific. The different types of houses are:

- Men's - 138
- Women's - 40
- Men with Children - 2
- Women with Children: 15

The complete list of Washington State houses by populations served and availability is at: http://www.dshs.wa.gov/pdf/hrsa/dasa/Directory/APPNDXH.pdf.
In FFY08, approximately $75,000 of federal funds was available for the revolving fund. The percentage of loans paid off is 99%. The numbers of loans beyond the two year repayment period were one.

Goal 7 Group Home Entities and Programs
FY 2010 PROGRESS

In FY 2010, DBHR elected to continue to support the development of group homes for recovering substance abusers through the operation of a revolving loan fund.

As of August 2010, the total number of new houses opened during FFY 2010 is 13. Bed capacity per day is 1,980 and represents a 16% increase from FFY 2008. From these 13 new houses, there was an addition of eight new houses for men, three new houses for women, one new house for women with children, and one new house for men with children. Currently there are a total of 220 Oxford Houses in the State of Washington.

During this period, 13 new houses were opened and four houses were closed. The majority of the active houses are located in Western Washington along the Interstate 5 corridor from the Canadian border to the Oregon State line. The houses in the State of Washington are gender specific houses. As of May 2010, there were:

- Men's : 152
- Women's : 43
- Men with Children: 3
- Women with Children: 18

This equals a 2.85% growth rate for Federal Fiscal Year 2009. For a complete list of Washington State houses, populations served, and availability go to:
http://www.dshs.wa.gov/pdf/hrsa/dasa/Directory/APPNDXH.pdf.
In FFY10, approximately $120,000 of federal funds was available for the revolving fund. At the time of report, the percentage of loans paid off is 92%.

Changes from previous years' operations:

- On October 15, 2009, Oxford Houses of Washington State dedicated their 200th house naming it the Stark Oxford House in honor of Mr. Ken Stark. Mr. Stark provided leadership to the development of the program. He was the Director of the Washington State Division of Alcohol and Substance Abuse (DASA) now known as the Division of Behavioral Health and Recovery for many years, and championed the effort to start supportive housing opportunities for those in recovery in Washington State. In 1994, Mr. Stark began the effort of establishing Oxford Houses across the state. In the effort to do this, he hired an outreach services representative to establish Oxford Houses in Washington. The program expanded at such a fast pace that Mr. Stark assigned a program manager to work alongside the outreach representative to monitor expansion and revolving loan repayments. Mr. Stark, years ago, had stated that he would like to see Washington State have 200 houses, so Oxford House Inc., decided that the 200th house would be named after Ken Stark.

- Stan Timberlake, an outreach services representative for Oxford Houses of Washington passed away on January 11, 2010. Stan worked with Oxford Houses for five years. Stan will be greatly missed not only by his peers, co-workers, and staff from the Division of Behavioral Health and Recovery, but by anyone that has ever had any interactions with him. He was passionate about recovery, Oxford House Principles, and life.

  On February 1, 2010, a new Oxford House outreach services representative was hired to replace Stan and we continue with six Oxford House outreach representatives in Washington State.

- During the 12th Annual Oxford House World Convention September 2-5, 2010, in Chicago, IL. A special meeting was called involving Oxford House members who were attending the conference. The meeting was to vote on a ruling to allow all Oxford Houses throughout the world the choice to vote in new residents that were in Opiate Substitution Treatment and taking Methadone or Suboxone. The vote was ratified with a majority of those attending. Oxford House Inc. will change their policy and procedures and tracking outcomes through a change in their yearly surveys adding questions regarding Methadone and Suboxone. The results of the survey will be shared with the Division of Behavioral Health and Recovery annually.

Group Home Entities and Programs (formerly Attachment F)

(See 42 U.S.C. §300x-25)

If the State has chosen in FY 2008 to participate and support the development of group homes for recovering substance abusers through the operation of a revolving loan fund, the following information must be provided.

Provide a list of all entities that have received loans from the revolving fund during FY 2008 to establish group homes for recovering substance abusers. In a narrative of **up to two pages**, describe the following:

- the number and amount of loans made available during the applicable fiscal years;

- the amount available in the fund throughout the fiscal year;

- the source of funds used to establish and maintain the revolving fund;

- the loan requirements, application procedures, the number of loans made, the number of repayments, and any repayment problems encountered;

- the private, nonprofit entity selected to manage the fund;

- any written agreement that may exist between the State and the managing entity;

- how the State monitors fund and loan operations; and

- any changes from previous years' operations.

Group Home Entities and Programs

The number and amount of loans made available during the applicable fiscal years:

In FFY 2008, Washington State participated and supported the development of new group homes for recovering substance abusers through the operation of a revolving loan fund.

During FFY 2008, 24 new Oxford Houses opened. This represents a 9% increase from FFY07 and brings the total number of Oxford Houses in the state to 194; with a bed capacity of 1,552 beds per day. Of the new houses, fourteen were for men, six for women, and four houses for women with children.

The following entities received loans from the revolving fund to establish group homes for recovering substance abusers. The location of the home, the date the loans were initiated and repayment status as of September 31, 2008 are as follows:

HOUSE NAME	STREET ADDRESS	CITY	OPEN DATE	LOAN AMT	LOAN DATE	AMT OWING as of 07/31/08
Colman Park	1907 20th Avenue South	Seattle	09/01/2007	$4,000.00	08/22/2007	$125.00
Covington	18011 SE 265th Place	Covington	09/01/2007	$4,000.00	08/24/2007	$260.00
Shattuck Creek	9412 NE 135th Lane	Kirkland	09/01/2007	$4,000.00	08/22/2007	$260.00
Robertson	1415 East 61st Street	Tacoma	10/01/2007	$4,000.00	09/19/2007	$795.00
Ruddell Road	5505 32nd Ct. SE	Lacey	10/01/2007	$4,000.00	09/24/2007	$60.00
Richland	1007 Sunset St	Richland	12/01/2007	$4,000.00	11/26/2007	$990.00
Betty Miller	3714 G Street	Vancouver	01/01/2008	$4,000.00	12/20/2007	$1,380.00
Hill	2103 21st Ave S	Seattle	01/01/2008	$4,000.00	12/10/2007	$940.00
Memory Lane	308 SW 3rd Ave	Kelso	01/01/2008	$4,000.00	12/10/2007	$940.00
Illinois	722 East Illinois Avenue	Spokane	02/01/2008	$4,000.00	01/15/2008	$965.00
Silver Creek	19202 74th Ave. West	Lynnwood	02/01/2008	$4,000.00	01/25/2008	$1,085.00
South East Oly	1103 McCormick Street S	Olympia	02/01/2008	$4,000.00	01/22/2008	$1,110.00
Orchard Heights	11408 NE Conifer Drive	Vancouver	03/01/2008	$4,000.00	02/22/2008	$0.00
Tenny Creek	2825 NE 85th Street	Vancouver	03/01/2008	$4,000.00	02/22/2008	$430.00
Clark	632 West Clark Street	Pasco	03/15/2008	$4,000.00	03/11/2008	$2,060.00
Aberdeen	701 W 3rd Street	Aberdeen	04/01/2008	$4,000.00	03/21/2008	$1,450.00
Scott King	19261 Occidental Ave S	Des Moines	04/01/2008	$4,000.00	03/24/2008	$1,125.00
Birchwood	2624 Birchwood Avenue	Bellingham	05/01/2008	$4,000.00	04/30/2008	$1,620.00
Cannon	1414 West 13th Avenue	Spokane	05/01/2008	$4,000.00	04/30/2008	$1,620.00
Interlake	10014 Interlake Avenue N	Seattle	05/01/2008	$4,000.00	04/21/2008	$1,620.00
Oyster Bay	925 Wilbert Ave	Bremerton	06/01/2008	$4,000.00	05/20/2008	$1,375.00
Dishman Hills	223 South Sergeant Road	Spokane Valley	07/01/2008	$4,000.00	06/17/2008	$2,545.00
Jericho	2269 Jericho Road	Richland	07/01/2008	$4,000.00	06/17/2008	$2,130.00
Court Street	3613 West Opal Place	Pasco	08/01/2008	$4,000.00	07/23/2008	$2,320.00

The amount available in the fund throughout the fiscal year:

In FFY 2008, approximately $115,825.00 of federal funds was made available for the revolving fund. There were 24 new loans and 16 loans paid off. The percentage of payoffs on the loan was 100.8% percent. The fiscal reconciliation is available on the following report.

The loan requirements, application procedures:

Loans, up to $4,000.00, were provided to eligible Oxford House entities. Each group home served at least eight individuals recovering from alcohol and/or drug abuse. The loans were interest free; required monthly payments and carried late charges of $25.00 or 20 percent of the outstanding balance for delinquent payments; and, are required to be repaid within two years from the date of the loan.

The number of loans made, the number of repayments, and any repayment problems encountered:
The State of Washington monitored the revolving fund using a direct contract between Oxford House Inc. and DBHR. Below is a summary of the Oxford House Revolving Account:

	July-08	August-08	September-08
Total number of houses	193	193	194
Number of current loans	54	50	53
New house loans	2	0	4
Dollar amount of loans	$8,000.00	$0.00	$16,000.00
Number of loans beyond 2 yrs. repayment period	2	1	1
Dollar value of loans beyond 2 yrs. repayment period	$1,750.00	$150.00	$800.00
Late Fees Collected	$125.00	$0.00	$25.00
Outstanding loan balance	$112,275.00	$100,125.00	$115,825.00
Balance in account, West Coast Bank	$4,744.84	$744.95	$745.50
Balance in account, West Coast Bank	$68,570.68	$77,818.44	$73,993.33
Total	**$185,590.52**	**$178,688.39**	**$190,563.83**

HRSA/Division of Rates and Finance prepared by David Bollinger 10/29/2008

In FFY 2008, Washington State had a repayment percentage of 100%, which is number one in the nation. Virginia and North Carolina follow with 89.1% and 80.7%, respectively.

The private, nonprofit entity selected to manage the fund:
The Oxford House organization, a national non-profit organization, was selected to manage the Revolving funds for the establishment of new houses. The Oxford House, Inc. offers a housing concept that is self-run and self-supported by and for recovering alcoholics and drug addicts. Each group recovery home in operation was provided a charter from Oxford House, Inc. – the 501(c) (3) nonprofit umbrella organization. The charter are first granted on a conditional basis to assure that the new group of recovering individuals understands the standard system of operation required to make an Oxford House successful. Each charter establishes a unique entity with its own Federal Tax Identification Number (FEIN), checking account, and unique identification.

The Division of Behavioral Health and Recovery (DBHR) entered into a contract with Oxford House, Inc. to administer the following specific aspects of the loan program:

1) Coordinate, approve, and manage loan applications to finance the start-up of Recovery Homes
2) Management of loans to include collections, remittance, invoicing, late payment notices, and telephone assistance
3) Manage information, including reporting and audits, to meet State and Federal requirements

Oxford House submitted to the DBHR Contract Manager a monthly Oxford House Development Progress Reports on the status of each home in operation and those in the planning states. The report included: statistics on the program's performance, expenditure reports, and narratives describing overall progress.

Changes from previous years' operations are identified as following:
For Federal Fiscal Year 2008: Starting on July 1, 2007, the DBHR Fiscal Department developed a log to monitor the Oxford House contract more closely. The fiscal log monitored the revolving fund on a monthly basis and a monthly update was placed on the internal F: SHARED server.

Goal #8: Tobacco Products

An agreement to continue to have in effect a State law that makes it unlawful for any manufacturer, retailer, or distributor of tobacco products to sell or distribute any such product to any individual under the age of 18; and, to enforce such laws in a manner that can reasonably be expected to reduce the extent to which tobacco products are available to individuals under age 18 (See 42 U.S.C. §300x-26, 45 C.F.R. §96.130 and 45 C.F.R. §96.122(d)).

• Is the State's FY 2011 Annual Synar Report included with the FY 2011 uniform application? (Yes/No)

• If No, please indicate when the State plans to submit the report: (mm/dd/2010)

Note: The statutory due date is December 31, 2010.

Washington State Synar Report will be completed and submitted no later than December 31,2010.

Goal #9: Pregnant Women Preferences

An agreement to ensure that each pregnant woman be given preference in admission to treatment facilities; and, when the facility has insufficient capacity, to ensure that the pregnant woman be referred to the State, which will refer the woman to a facility that does have capacity to admit the woman, or if no such facility has the capacity to admit the woman, will make available interim services within 48 hours, including a referral for prenatal care (See 42 U.S.C. §300x-27 and 45 C.F.R. §96.131).

Note: In addressing this narrative the State may want to discuss activities or initiatives related to the provision of: *Priority admissions; Referral to Interim services; Prenatal care; Provider contracts; Routine reporting; Waiting lists; Screening/assessment; Residential treatment; Counseling; Training/TA Educational materials; HIV/AIDS/TB Testing*

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

Goal 9: FY 2011 - 2013 (Intended Use):

Introduction: The goal for FY 2011 – 2013 will ensure that pregnant women receive preference for admission to treatment facilities. If facilities are unable to admit, due to capacity issues, the state will be required to be notified and the Family Services Manager or Regional Treatment Manager. DBHR staff will help to facilitate pregnant woman into treatment services. If no treatment services are available, interim services will be provided, either by an outpatient treatment agency, the residential agency, or other provider. This will will also include a referral to prenatal care if the pregnant woman is not receiving prenatal care.

Activity 9-1

The goal for FY 2011 – 2013 will be to ensure pregnant women receive preference in admission to treatment and priority referral to facilities with capacity to admit them. The requirement that pregnant women be given admission priority will be included in all contracts issued to residential treatment agencies, and contracts with counties for outpatient services for the 2011-2013 biennium:

Ensure that eligible persons in the categories listed below are given priority status in this order of precedence when seeking services.

(1) SAPT Block Grant Requirements:

(a) Pregnant injecting drug users

(b) Pregnant substance abusers

(c) Injecting drug users

(2) Washington State additional priority populations (b through f are in no priority order):

(a) Parenting women (first priority)

(b) Postpartum (up to one year, regardless of pregnancy outcome)

(c) Parents involved with Child Protective Services

(d) Youth

(e) Other Medicaid eligible clients

(f) Offenders (as defined in RCW 70.96A.350)

(3) All others

Assessment entities, which will be available statewide, will refer women anywhere in the state for residential treatment to ensure the earliest possible admit date for appropriate treatment.

In addition to the regular treatment system that DBHR funds, Medicaid will fund detoxification beds specifically for pregnant women in hospital based settings, known as Chemical Using Pregnant (CUP). These facilities will be typically accessed within 24 hours of referral and will be a good resource when treatment beds are full and a pregnant woman is in need of immediate medical care. The stay in a CUP bed will be up to 26 days.

Activity 9-2

To meet the requirement of publicizing the priority populations to patients, DBHR designed a poster (see attachment) and it has been distributed to all publicly funded treatment providers in Washington State. This poster will be posted at each treatment agency to inform individuals of the priority populations. The requirement to publicize the priority populations will be included in the 2011-2013 biennium contracts for the counties and was added in the Adult Residential contracts in July 2010:

> Per the SAPT Block Grant requirements, contractors must publicize information regarding the priority populations in a public area of their facility.

Activity 9-3

The goal for FY 2011 - 2013 will be to ensure interim services and referral for prenatal care will be provided to women waiting for an appropriate treatment admits. Contracts with all outpatient and residential providers will continue to require them to provide interim services to pregnant women in the event that there is a wait for treatment:

(1) Interim services for Substance Abuse Prevention and Treatment (SAPT) Block Grant patients shall be entered into TARGET on the Support Services form (DSHS 04-419). Interim services must be documented in the patient record and include at a minimum:

(a) Provision of, or referral to counseling on the effects of alcohol and drug use on the fetus for the pregnant patient.

(b) Referral for prenatal care for the pregnant patient.

(c) Provision of or referral to human immunodeficiency virus (HIV) and tuberculosis (TB) education.

(d) Referral for HIV or TB treatment services if necessary for an intravenous drug user.

All services along the continuum from outreach to aftercare and referral of pregnant women to prenatal care will also include the Parent Child Assistance Program (see attachment), Safe Babies Safe Moms (see attachment), and First Steps (see attachment).

DBHR added a data set in TARGET that requires providers to identify interim service referrals for the priority populations. This TARGET element was available on July 1, 2010. DBHR Regional Treatment Managers will monitor agencies, through the Treatment and Report Generation Tool (TARGET) database, for compliance with this requirement. If it is discovered that a provider is not entering the correct data into TARGET, then technical assistance will be provided to the provider to meet this requirement. The interim services TARGET requirement will be added to the 2011-2013 biennium contracts for the counties and will continue in the Adult Residential contracts.

DBHR will continue to have contract language with all 39 counties and 29 tribes that require assessment services for pregnant women within 48 hours of referral and treatment admission in no later than seven days. Counties will also be required to ensure their subcontractors provide interim services when comprehensive care is not immediately available.

Prenatal Care: Each provider will continue to be responsible, per contract language (outpatient and residential) (see 9-2 above), to identify prenatal needs and refer to a medical provider, as necessary. DBHR programs will not provide prenatal care.

Goal 9 PPW Admission Preference
FY 2008 (Compliance):

The goal in FY 2008 was to ensure that pregnant women received preference statewide for admission to treatment facilities. This goal was met by requiring facilities that were unable to admit, due to capacity issues, to notify the Family Services Manager or Regional Treatment Manager who then helped to facilitate admission into treatment services elsewhere. If no treatment services were available, interim services were provided within 48 hours, either by an outpatient treatment agency, the residential agency, or other provider, which included a referral to prenatal care.

This requirement was included in all contracts issued to adult residential treatment agencies, and contracts with for outpatient services:

For outpatient contracts, language included:

c. Pregnant and Parenting Women.

The County/Tribe shall ensure pregnant and parenting women in need of treatment or who are referred for treatment shall be given admission preference to treatment facilities receiving block grant funds.

For Adult Residential contracts:

(2) Ensure treatment admissions are prioritized as follows
   (a) Parent with a child under eighteen years old in the home
   (b) Patient referred by the department's Child Protective Services (CPS) program
   (c) Intravenous injecting drug user (IVDU)

b. Ensure that priority to admission is given to:
   (a) Pregnant Women;
   (b) Intravenous Drug Users (IDUs);
   (c) Persons infected with HIV/AIDS;
   (d) Parents with children in the home; and
   (e) Child Protective Service (CPS) referrals.

Assessment entities ensured the earliest possible admit date for appropriate treatment by referring women anywhere in the state for residential treatment.

In addition to the regular treatment system that DBHR funded, Medicaid funded detoxification beds specifically for pregnant women in hospital based settings, known as a Chemical Using Pregnant (CUP). These facilities were typically accessed within 24 hours of referral and were a good resource when treatment beds were full and the pregnant woman was in need of immediate medical care. The stay in a CUP bed was up to 26 days.

The goal for FY 2008 was to provide interim services and referrals for prenatal care for women awaiting an appropriate treatment admission. Contracts with all outpatient providers required them to provide interim services for pregnant women in the event that there was a wait for treatment:

Outpatient contract language included:

d. Childcare and Prenatal Care:
The County shall, directly or through arrangements with other public or nonprofit private entities, make available prenatal care and childcare to women receiving treatment services.
Adult Residential contract language included:
(3) Childcare and Prenatal Care Required: The Contractor shall, directly or through arrangements with other public or nonprofit private entities, make available prenatal care and

childcare to parents receiving treatment services.

The state contracts for services along the continuum from outreach to aftercare and referral of pregnant women to prenatal care and also included the Parent Child Assistance Program (see attachment), Safe Babies Safe Moms (see attachment), and First Steps (see attachment).

DBHR executed contracts with all 39 counties and 29 tribes that required assessment services for pregnant women within 48 hours of referral and treatment admission in no later than seven days. Providers were also required to provide interim services when comprehensive care was not immediately available.

Prenatal Care: Each provider was responsible, per contract (outpatient and residential) (as identified in 9-2 above), to identify prenatal needs and refer women to a medical provider if necessary. DBHR programs did not provide prenatal care.

Goal 9: PPW Admission Preference
FY 2010 (Progress):

The goal for FY 2010 is to ensure that pregnant women receive preference statewide for admission to treatment facilities. When facilities are unable to admit, due to capacity issues, the state is required to be notified and the Family Services Manager or Regional Treatment Manager will help to facilitate the admission of a pregnant woman into alternative treatment services. If treatment services are not available, interim services are provided within 48 hours, either by an outpatient treatment agency, the residential agency, or other provider, which may include a referral to prenatal care.

A Core Technical Review, held in 2009, reported that priority populations identified in contracts did not match the priority populations outlined in the SAPT Block Grant. Subsequently, we amended the contracts to include the correct priority populations: 1. Pregnant Injecting Drug Users, 2. Pregnant Substance Abusers, and 3. Injecting Drug Users. DBHR also identified Parenting Women as the fourth priority population.

Assessment entities, which are available statewide, refer women anywhere in the state for residential treatment to ensure the earliest possible admit date for appropriate treatment.

In addition to the regular treatment system that DBHR funds, Medicaid funds detoxification beds specifically for pregnant women in hospital based settings, known as Chemical Using Pregnant (CUP) facilities. These facilities are typically accessed within 24 hours of referral and are a good resource when treatment beds are full and the pregnant woman is in need of immediate medical care. The stay in a CUP bed is up to 26 days.

To meet the requirement of publicizing the priority populations to patients, DBHR designed a poster (see attachment) and distributed it to all publicly funded treatment providers in Washington State. This poster will be posted at each treatment agency to inform individuals of the priority populations. The requirement to publicize the priority populations was added to the Adult Residential contract beginning July 2010.

To ensure interim services and referral for prenatal care is provided to women waiting for an appropriate treatment admits contracts with all providers included this requirement.

Outpatient contracts read:

d. Childcare and Prenatal Care:
The County shall, directly or through arrangements with other public or nonprofit private entities, make available prenatal care and childcare to women receiving treatment services.

Adult Residential contracts read:

(2) Childcare and Prenatal Care Required: The Contractor shall, directly or through arrangements with other public or nonprofit private entities, make available prenatal care and childcare to parents receiving treatment services.

DBHR contracts for services along the continuum, from outreach to aftercare and referral of pregnant women to prenatal care and also includes the Parent Child Assistance Program (see attachment), Safe Babies Safe Moms (see attachment), and First Steps (see attachment).

DBHR added a data set in TARGET that requires providers to identify interim service referrals for the priority populations. This requirement was amended into contracts beginning July 2010.

DBHR has language in all contracts that require assessment services for pregnant women within 48 hours of referral and treatment admission within seven days. Counties also are required to ensure their subcontractors provide interim services when comprehensive care is not immediately available.

Prenatal Care: Each provider is responsible, per contract language (outpatient and residential) (see 9-2 above), to identify prenatal needs and refer to a medical provider, as necessary.

Capacity Management and Waiting List Systems (formerly Attachment G)

See 45 C.F.R. §96.122(f)(3)(vi))

For the fiscal year two years prior (FY 2009) to the fiscal year for which the State is applying for funds:

In **up to five pages**, provide a description of the State's procedures and activities undertaken, and the total amount of funds expended (or obligated if expenditure data is not available), to comply with the requirement to develop capacity management and waiting list systems for intravenous drug users and pregnant women (See 45 C.F.R. §96.126(c) and 45 C.F.R. §96.131(c), respectively). This report should include information regarding the utilization of these systems. Examples of **procedures** may include, but not be limited to:
<

• development of procedures (and any subsequent amendments) to reasonably implement a capacity management and waiting list system;

• the role of the Single State Agency (SSA) for substance abuse prevention and treatment;

• the role of intermediaries (county or regional entity), if applicable, and substance abuse treatment providers; and

• the use of technology, e.g., toll-free telephone numbers, automated reporting systems, etc.

Examples of **activities** may include, but not be limited to:

• how interim services are made available to individuals awaiting admission to treatment ;

• the mechanism(s) utilized by programs for maintaining contact with individuals awaiting admission to treatment; and

• technical assistance.

This narrative response not included because it does not exist or has not yet been submitted. Please submit a request to the BGAS helpdesk for further inquiry.

Goal #10: Process for Referring

An agreement to improve the process in the State for referring individuals to the treatment modality that is most appropriate for the individual (See 42 U.S.C. §300x-28(a) and 45 C.F.R. §96.132(a)).

Note: In addressing this narrative the State may want to discuss activities or initiatives related to the provision of: *Training/TA; Implementation of ASAM criteria; Use of Standardized assessments; Patient placement using levels of care; Purchased/contracted services; Monitoring visits/inspections; Work groups/task forces; Information systems; Reporting mechanisms; Implementation protocols; Provider certifications.*

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

GOAL # 10 Improve the process for referring individuals to treatment
FFY 2011 - 2013 (Intended Use)

In order to support a state-wide approach that ensures patients are referred to treatment modalities based upon the most appropriate level of service, DBHR requires publicly-funded certified agencies to use an Assessment/Admission Record and Patient Placement Criteria (PPC*)* addendum for conducting initial chemical dependency assessments, continued service, and discharge planning clinical activities. Privately-funded certified agencies are required to use forms and procedures that include the same data elements as public-funded certified agencies. Examples of required and alternative biopsychosocial assessments that meet *PPC* requirements are found at:
http://www.dshs.wa.gov/DASA/services/certification/Forms/PatientPlaceForms.shtml.

WAC 388-805-310(4) further requires certified agencies to develop a diagnostic assessment statement and written summary of the assessment that supports treatment recommendations and the appropriate level of service. WAC 388-805-315 requires certified agencies to develop individualized patient treatment plans and update treatment plans based upon updates to the assessment throughout treatment.

All DBHR-certified and contracted chemical dependency treatment agencies will also be required to provide a core set of clinical services to each patient admitted for treatment. The core set of clinical services are described in WAC 388-805- 100(3) and are referred to as the essential requirements for chemical dependency treatment. The essential requirements of treatment include chemical dependency assessments, treatment planning, documenting patient progress, treatment plan reviews, patient compliance reports, continuing care, transfer, and discharge planning.

DBHR-certified agencies will be monitored for compliance with the regulations governing assessments and referrals as required by Washington Administrative Code (WAC) 388-805 through regular scheduled on-site surveys. *Certification Requirements for Chemical Dependency Service Providers* is located at:
http://apps.leg.wa.gov/wac/default.aspx?cite=388-805

Continued service reviews serve to evaluate patient progress on their treatment plan. Service reviews evaluate appropriate level of service as regulated by WAC. For example, WAC 388-805-530(1)(d) requires weekly treatment plan review with a continued service review. WAC 388-805-610(1)(f) and 620(4) requires treatment plan reviews with continued service review at least once a month during treatment.

During FFY 2011-2013, the DBHR Certification staff will continue to schedule and monitor requirements for standardized assessments while conducting on-site surveys of certified agencies. Certification staff will recommend agencies adopt the Section's sample assessment form or ensure that the agency's assessment form contain all requirements of WAC 388-805-310. DBHR Certification staff members expect to complete 180 individual agency on-site surveys per each FFY. The average number of state-certified programs should be about 590 during this period.

During each on-site survey, DBHR Certification Specialists will use extensive checklists while conducting patient record reviews to assess compliance with the WAC 388-805 requirements listed above.

After each on-site survey, Certification Specialists will complete an on-site survey report that lists deficiencies and requests corrective action plans. Follow-up on-site surveys will be completed to ensure implementation of corrective actions.

All DBHR-certified agencies will be required to implement policies and procedures, per contract, for the development and implementation of a capacity management/waiting list system.

Access to the toll-free Alcohol Drug Helpline will continue to be available to DBHR certified agencies to report and coordinate capacity of state-funded youth residential treatment beds. Agencies will also refer prospective patients to the Alcohol Drug Helpline when seeking services based upon bed availability across Washington State. The Alcohol Drug Helpline is located at: http://www.adhl.org/ or at 1-800-562-1240.

All DBHR contracts will continue to require publicly-funded treatment providers to enter Date of First Contact information into TARGET. Reports from the TARGET will indicate length of time that has lapsed between the Date of First Contact and the Date of First Offered Service. The Date of First Accepted Service element allows an agency to account for patient choice when selecting available dates for treatment. If a patient chooses a date other than the first available date, the Date of First Accepted Service will document the patient choice.

This information will be utilized to ensure that patients enter services as quickly as possible and that Interim services are provided. Compliance will be reviewed by DBHR Regional Administrators and Regional Treatment Managers during on-site reviews.

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GOAL # 10 - Improve the process for referring individuals to treatment
FFY 2008 (Compliance)

DBHR, through WAC 388-805 required all certified chemical dependency service providers (certified agencies) to provide a core set of clinical services to each patient admitted for treatment. The core set of clinical services are described in WAC 388-805-100(3) and are referred to as the essential requirements for chemical dependency treatment. DBHR also enacted rules requiring agency administrators to hire sufficient qualified personnel to provide adequate treatment services, facility security, patient safety and to meet special needs of patients [WAC 388-805-145(4) and Section 150(5)]. Certification Requirements for Chemical Dependency Service Providers is located at: http://apps.leg.wa.gov/wac/default.aspx?cite=388-805.

In regards to enacting state rules to improve the process for referring individuals to the treatment modality that is most appropriate, DBHR enacted, implemented, and monitored a number of requirements through WAC 388-805.

DBHR, through WAC 388-805-300(5) required all certified agencies use the American Society of Addiction Medicine's *Patient Placement Criteria (*PPC*)* for determining admission, continued service, and discharge planning clinical activities. WAC 388-805-310(2) required all certified agencies to evaluate assessment elements using PPC dimensions for patient placement decisions (referral). WAC 388-805-310(4) further required certified agencies to develop a diagnostic assessment statement and written summary integrating assessment information support treatment recommendations and the appropriate level of service. WAC 388-805-315 required certified agencies to develop individualized patient treatment plans and update treatment plans based upon a patient's assessment and updates through continued treatment service review. Continued service reviews serve to evaluate patient progress on his/her treatment plan and evaluate the appropriate level of care. Continued service reviews to evaluate appropriate level of service are also regulated by WAC. For example, WAC 388-805-530(1)(d) requires weekly treatment plan review with a continued service review. WAC 388-805-610(1)(f) and 620(3) require treatment plan reviews with continued service review at least once a month during treatment.

In order to support a state-wide approach that ensured patients are referred to treatment modalities based upon the most appropriate level of service, DBHR required public-funded certified agencies use an Assessment/Admission Record and PPC addendum for conducting initial chemical dependency assessments. Private certified agencies were required to use forms and procedures that included the same data elements as public-funded certified agencies but some developed assessment documents that included additional information. Examples of required and alternative biopsychosocial assessments that meet *PPC* requirements are found at: http://www.dshs.wa.gov/DASA/services/certification/Forms/PatientPlaceForms.shtml.

The DBHR Certification staff conducted monitoring activities by completing individual agency on-site and technical assistance surveys in 2007/08. The total number of state-certified programs on September 30, 2008, was 577. By September 30, 2008, the DBHR Certification staff had completed about 175 (137 routine and 38 corrective action plan implementation) on-site and technical assistance surveys during the year.

During each on-site survey, DBHR Certification Specialists used extensive checklists while conducting patient record reviews to assess compliance with WAC 388-805 requirements. Certification Specialists completed on-site survey reports that listed each deficiency, requested corrective action plans, and conducted follow-up on site surveys to ensure implementation of corrective action. For FFY 2008, DBHR-certified agencies met approximately 95 percent of all requirements for referring individuals to treatment facilities that could provide the treatment modality most appropriate for the individual. DBHR

Certification Specialists documented some agency assessment deficiencies per WAC 388-805-310 which required agencies to provide corrective action. DBHR Certification Specialists worked with those agencies that required technical assistance to improve compliance rates.

All outpatient contracts contained language that required certified agencies to use state-approved chemical dependency assessment formats and required certified agencies to meet WAC 388-805 requirements. This language ensured indigent and low-income persons eligible for publicly funded services received appropriate referral to treatment.

Compliance was monitored by DBHR Regional Administrators and Regional Treatment Managers; the monitoring reports and elements of review are included in the Appendices.

GOAL 1 - Improving the process for referring individuals to treatment
FFY 2010 (Progress)

The Washington State Division of Behavioral Health and Recovery (DBHR) improved the process for referring individuals to treatment that can provide the most appropriate treatment modality. The process includes utilization of a standardized adult and youth assessment form. The standardized form is located at: http://www.dshs.wa.gov/DASA/services/certification/Forms/PatientPlaceForms.shtml.

DBHR-contracted certified agencies are monitored for compliance with regulations governing assessments and appropriate client referrals as required by Washington Administrative Code (WAC) 388-805 through regular scheduled on-site surveys. WAC 388-805, *Certification Requirements for Chemical Dependency Service Providers* is located at: http://apps.leg.wa.gov/wac/default.aspx?cite=388-805.

DBHR-certified and contracted chemical dependency treatment agencies are required to implement procedures that support capacity and waiting list systems.

All DBHR-contracted certified agencies are required to have policies and procedures per WAC 388-805 that require a standardized assessment procedure. As part of the initial DBHR-certification process, DBHR staff review and verify each new agency's policies and procedures to ensure they meet the requirements of WAC 388-805 sections 300(5), and 310 to implement standardized assessment procedures.

In addition, DBHR Regional Administrators and Regional Treatment Managers monitor contracts for FFY 2010 to assure that agencies/providers are completing standardized assessments and making the most appropriate referrals for publicly-funded individuals.

DBHR, through WAC 388-805, continues to require all DBHR-certified and contracted chemical dependency treatment agencies to provide a core set of clinical services to each patient admitted for treatment. The core set of clinical services are described in WAC 388-805-100(3) and are referred to as the essential requirements for chemical dependency treatment. DBHR also enacted rules requiring agency administrators to hire sufficient qualified personnel to provide adequate treatment services, facility security, patient safety and to meet special needs of patients [WAC 388-805-145(4) and Section 150(5)].

DBHR, through WAC 388-805-300(5) requires all certified agencies to use Patient Placement Criteria (*PPC)* for determining admission, continued service, and discharge planning clinical activities. WAC 388-805-310(2) requires all certified agencies to evaluate assessment elements using *PPC* dimensions for patient placement decisions (referrals). WAC 388-805-310(4) further requires certified agencies to develop a diagnostic assessment statement and written summary integrating assessment information to that support treatment recommendations and the appropriate level of service. WAC 388-805-315 requires certified agencies to develop individualized patient treatment plans and update treatment plans based upon a patient's assessment and updates through continued treatment service reviews.

Continued service reviews serve to evaluate patient progress on his/her treatment plan and evaluate the appropriate level of care. Continued service reviews to evaluate appropriate level of service are also regulated by WAC. For example, WAC 388-805-530(1)(d) requires weekly treatment plan review with a continued service review. WAC 388-805-610(1)(f) and 620(4) requires treatment plan reviews with continued service review at least once a month during treatment.

In order to support a state-wide approach that ensures patients are referred to treatment modalities based upon the most appropriate level of service, DBHR requires public-funded certified agencies to use an *Assessment/Admission Record* and *PPC* addendum for conducting initial chemical dependency assessments. Privately-funded certified agencies are required to use forms and procedures that include the same data elements as public-funded certified agencies. Examples of required and alternative biopsychosocial assessments that meet *PPC* requirements are found at: http://www.dshs.wa.gov/DASA/services/certification/Forms/PatientPlaceForms.shtml.

During FFY 2010, the DBHR Certification staff are scheduling and monitoring the requirements for standardized assessments while conducting on-site surveys of certified agencies. DBHR Certification staff completed 80 on-site surveys from October 1, 2009, through August 31, 2010. We anticipate completing another 70 on-site surveys for a total of about 150 on-site surveys by the close of FFY 2010. The average number of state-certified programs should be about 590 during this period.

During each on-site survey, DBHR Certification Specialists use extensive checklists while conducting patient record reviews to assess compliance with the WAC 388-805 requirements listed above.

After each on-site survey, Certification Specialists complete an on-site survey report that lists deficiencies, requests corrective action plans, and conduct follow-up on-site surveys to ensure implementation of corrective action.

All contracts contain language that requires certified agencies to use state approved chemical dependency assessment formats that meet WAC 388-805 requirements. Contracts contain language to ensure indigent and low income persons eligible for publicly funded services receive appropriate referrals to treatment.

Publicly-funded certified agencies are required to implement policies and procedures for the development and implementation of a capacity management/waiting list system.

Publicly funded providers have access to and use the toll free Alcohol Drug Helpline to report and coordinate capacity of state-funded youth residential treatment beds. Agencies are able to refer prospective patients to the Alcohol Drug Helpline for seeking services based upon bed availability across Washington State. The Alcohol Drug Helpline is located at: http://www.adhl.org/ or 1-800-562-1240.

All DBHR contracts have been amended to require that Date of First Contact information be TARGET. Compliance is reviewed by DBHR Regional Administrators and Regional Treatment Managers during their on-site reviews. Reports from the DBHR MIS indicate the length of time that has lapsed between the Date of First Contact and the Date of First Offered Service. This information will be used to ensure that patients enter services as quickly as possible and that all elements of the SAPT Block grant regarding Interim services and Admission to treatment are met.

The Date of First Accepted Service element allows an agency to account for patient choice when selecting available dates for treatment. If a patient chooses a date other than the first available date, the Date of First Accepted Service will document the patient choice.

Reports are generated and reviewed by the contract manager to ensure all clients are appropriately placed and receive treatment with a reasonable timeframe.

Goal #11: Continuing Education

An agreement to provide continuing education for the employees of facilities which provide prevention activities or treatment services (or both as the case may be) (See 42 U.S.C. §300x-28(b) and 45 C.F.R. §96.132(b)).

Note: In addressing this narrative the State may want to discuss activities or initiatives related to the provision of: *Counselor certification; Co-occurring training; ATTCs training; Motivational interviewing training; HIV/AIDS/TB training; Ethics training; Confidentiality and privacy training; Special populations training; Case management training; Train-the-trainer model; Domestic violence training; Faith-based training; Suicide prevention training; Crisis intervention training.*

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

Goals 11- Continuing Education
FY2011-2013 (Intended Use)

In Washington State for certified Chemical Dependency Professional to maintain their certification, they must complete 28 hours of continuing education and 12 hours of other Professional Development Activities, for a total of 40 hours, every two years. The conferences supported by the SAPT block grant will assist counselors in maintaining their professional certification. Certified Prevention Specialist need a minimum of forty CEUs – specifically with twenty units in alcohol, tobacco and other drugs (ATOD) prevention education and twenty units in general prevention education to maintain certification.

For FY11 through FY13, continuing education opportunities will be provided each fiscal year to a minimum of a **1750 professionals,** this includes clinicians, supervisors, and administrators, working in the field of prevention or treatment of substance use disorders. The strategy to provide these training opportunities will be through statewide conferences and local regional trainings. Trainings will be provided with a coordinated approach to address and promote workforce development and to provide effective and quality clinical training. Trainings will be designed to meet r specific training needs identified through a county strategic plan or linked to state priorities and needs assessments.

Depending on the State's economic situation, we plan to coordinate the oversight of at least three statewide conferences annually. These conferences are: The Prevention Summit, The Co-Occurring Disorders and Treatment Conference, and the "Saying it Out Loud" conference. Counties may also choose to provide local trainings with contracted funds. Counties that provide continuing education training will required to submit an outline of the training to a DBHR Regional Administrator for verification the training is aligned with current objectives; evaluations of these trainings will be submitted as part of the Annual County Report.

Based on the historical high turnout at these conferences, the dates and locations for these conferences will remain consistent with past events. The Prevention Summit and Co-Occurring Disorders and Treatment conferences will be held in the fall in Yakima, Washington. The "Say it Out Loud" conference will be held in the spring in King County, WA. We will continue to contract with Washington State University and the Center for the Application of Substance Abuse Technologies to support the logistics of these events.

We will be working on an updated State needs assessment that will drive training decisions for FY11 through FY13.

The following areas are identified as state training needs for the future:

- Trauma-informed services in prevention, treatment and recovery programs;
- Ways to reduce barriers homeless persons with mental and substance use disorders and their families experience when accessing programs that sustain recovery;
- Development of Recovery Oriented Systems of Care;
- Patient care coordination.

We are committed to sustaining a competent workforce of Chemical Dependency Professionals and Prevention Professionals in Washington State who have the skill set to deliver effective services. With SAPT Block Grants funds dedicated to Continuing Education, Washington State will be able to support training for a diverse and competent workforce capable of meeting the needs of substance use involved individuals.

Goal 11 Continuing Education
FY 2008 (Compliance)

In FY 2008, DBHR provided continuing education opportunities for the employees of agencies that provide prevention and/or treatment services. To achieve this goal, DBHR held the following prevention or treatment conferences: Institute on Addictions Treatment Conference, the Co-Occurring Disorders Conference, the Prevention Summit, and the "Saying It Out Loud" conference. A total of **4938** professionals received continuing education through funds provided by the SAPT Block Grant. On average, annually there are 2500 active certified Chemical Dependency Professionals in the field. Based on the number of participants who attended the DBHR conferences and supported trainings, professionals accessed these opportunities. The level of attendance demonstrated that Chemical Dependency Professionals and Prevention Specialists in Washington State were exposed to state-of-the-art research and were provided evidence-based continuing education.

In Washington State for certified Chemical Dependency Professionals to maintain their certification, they must complete 28 hours of continuing education and 12 hours of other Professional Development Activities, for a total of 40 hours, every two years. The conferences supported by the SAPT block grant assisted in counselors maintaining their professional certification. A Certified Prevention Specialist needs a minimum of 40 CEUs – specifically with twenty units in alcohol, tobacco and other drugs (ATOD) prevention education and twenty units in general prevention education every two years to maintain certification.

Within Washington State there are six geographic regions; each region provided continuing education opportunities for professionals working in the field of prevention and treatment of chemical dependency. In Region One, seven trainings were provided and 378 participants attended. Trainings included: Motivational Interviewing, Comprehensive Substance Abuse Training, Law and Ethics and "Breaking down the Barriers through Cross Cultural Knowledge and Understanding." In Region Two, 109 attended one of three trainings provided: Preparing for the Department of Health Chemical Dependency Professional Exam, Motivational Interviewing and Ethics for CD Counselors. Region Three offered eleven trainings which provided continuing education for 667 participants. The trainings offered were: Ethics Training for Chemical Dependency Counselors, Substance Abuse Prevention Specialist Training, Blood-borne Pathogens, Motivational Interviewing, and Performance Based Prevention Service Regional Training. In Region Four, four Motivational Interviewing trainings were provided and 140 participants attended. Region Five presented twelve trainings which included: Methadone Myths and Facts, Relapse Prevention, Adolescent Treatment and the Family, Motivational Interviewing, Law and Ethics, and training on Co-Occurring Disorders. In Region Five, 337 professionals took the opportunity to receive continuing education. In Region Six, 403 attended one of the following trainings: Motivational Interviewing, Ethics Training, or The Native American Perspective presented by the Cowlitz Tribe.

Additional trainings were provided through contract with Office of Superintendent of Public Instruction and through contracts with the counties. The following counties provided continuing education opportunities in FY 2008: Columbia County, Klickitat County, Lincoln County, Pierce County, Skamania County, Clark County, and Whatcom County.

Activity 11-1: (Compliance)
Institute on Addictions Treatment Conference

Institute on Addictions Treatment Conference was held at the Yakima Convention Center in Yakima, WA in on June 25-27, 2008. The theme was "A Recovery Journey: Basics & Beyond". With **360** in attendance, the conference drew the largest attendance in the last three years for this particular

conference. This two and a half day conference brought together clinicians and administrators, as well as other professionals involved in the chemical dependency services. The Institute provided basic training to new counselors in the field and provided updated information to more experienced counselors. Workshops tracks provided included: Children, Youth and Family Services; Evidence Based Practices; Criminal Justice; Paths to Recovery – Community Support; Maximizing Public Health Resources; Medication, Pharmacology and the Treatment of Addiction; and Workforce Development. Trainings emphasized new evidenced based practices and effective therapeutic approaches for diverse populations.

Key note speakers included: H. Westley Clark, M.D., CSAT/SAMHSA; Joeseph Stone, PhD, Gallup Medical Center; John Gardin II, PhD, ADAPT; Andrew Saxton, M.D., Addiction Psychiatry Residency Program, University of Washington. Handouts from the Institute on Addictions Treatment Conference presentations are available at the sponsored DBHR link at http://casat.unr.edu/dasa/ . This conference offered 15 Continuing education credits to participants.

Activity 11-2: (Compliance)
Co-Occurring Disorders Conference

The Co-Occurring Disorders Conference was held on September 29-30, 2008 at the Yakima Convention Center in Yakima, Washington. The theme for this conference was "Embracing Best Practices that Change Lives." Participants from all parts of the state, representing a wide variety of treatment professionals, were in attendance. In FY2008, **611** participants received continuing education at this conference to improve their professional effectiveness.

The conference included training tracks on: Promising / Evidence Based Practices, Supportive Housing/Employment; Youth; Aging; Legal/ Corrections; Developmental Disabilities; Consumers; Medical; Traumatic Brain Injury; and Comprehensive Training. Keynote speaker for this conference included: Robert Rhode, Ph.D., University of Arizona Health Sciences Center and Rick Rosenthal, M.D., Professor of Clinical Psychiatry at Columbia University and Chairman of Psychiatry at St. Luke's Roosevelt Hospital Center, New York, NY. A sample of highlighted presentations included: Differential Diagnosis and Medication Issues for those with Severe Mental Illness and Combined Substance Disorders; Overcoming Unintentional Racism: Cross Cultural Competences in the Helping Profession; PTSD in Pregnant Women with Substance Abuse; Treatment and management of common co-occurring disorders in adolescents; Creating Trauma Informed Systems of Care.

Activity 11-3: (Compliance)
WA State Prevention Summit

The Prevention Summit was held on November 16 and 17^{t} 2007 at the Hilton Hotel in Vancouver, WA. For this conference **575 prevention professionals and youth** were in attendance. This conference provided both an adult track and a youth track. Presentations from the Summit included: A Culture of Intervention – New Science towards a New Approach presented by Jeff Jordan, MS; How the Tobacco and Alcohol Industries target youth presented by Erik Vistrand; Media Literacy presented by Erica Austin, PhD.; Internet Gambling; Social Branding and Youth Prevention; Adapting Cultural Traditions in TATU; Underage Drinking; a panel on Community Outreach, Recruitment and Engagement; Intervening in Destructive Decisions.
For those who attended, 12.5 Continuing Education Credits were available for Chemical Dependency Professionals in Washington State as well as for National Association of Alcoholism and Drug Abuse Counselors (NAADAC). Participants were able to use their certificate to apply for CEUs from other certification/licensing boards if needed.

DBHR staff with the input from stakeholders, youth and contracted support with Center for the Application of Substance Abuse Technologies provided coordination for the agenda, presenters and logistics for this conference.

Activity 11-4: (Compliance)
Saying it Out Loud Conference

The Saying it Out Loud Conference was held on May 9, 2008 in Shoreline, Washington; **248** participants attended this conference. The theme for the 2008 conference was "The Evolutions of Hope: Awareness, Planning and Action." The one-day conference brought together professionals from the diverse fields of social work, mental health, chemical dependency treatment, and substance abuse prevention to focus on chemical dependency and its impact in the Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) community. This conference provided current resources and research on issues related to addictions and the LGBTQ community.

The keynote speaker was Marsha Botzer who presented "Identity and Citizenship - Rights and the Individual in a Time of Absolutes" and closed the conference with the presentation entitled "The Moment of Proof: Who Are You?" The conference workshops and trainers provided the following: Doug North, presented an update on the DASA LGBTQ Workgroup; John Furze presented information from the Sexual Minority Subcommittee, Mental Health Division; Pat Wright and the Total Experience Gospel Choir performed; and a Plenary by Thomas Howard, from the Matthew Shepard Foundation, on "Erase Hate: A Community Discussion." The Children's Administration presented the video "We Are…GLBTQ."

Also in attendance and presenting were the following: Robin Arnold-Williams, Secretary Department of Social and Health Services; Frances Carr, Director Office of Diversity Affairs ; Doug Porter, Assistant Secretary Health and Recovery Services Administration; Douglas Allen, Director Division of Alcohol and Substance Abuse Richard Kellogg, Director Mental Health Division.

Note: Refer to the DBHR Training Table for overview of all regional and statewide trainings.

Goal 11 Continuing Education
FY 2010 (Progress)

In Washington State for certified Chemical Dependency Professional to maintain their certification, they must complete 28 hours of continuing education and 12 hours of other Professional Development Activities, for a total of 40 hours, every two years. The planned conferences supported by the SAPT block grant assist in counselor's maintaining their professional certification. Certified Prevention Specialist need a minimum of forty CEUs – specifically with twenty units in alcohol, tobacco and other drugs (ATOD) prevention education and twenty units in general prevention education every two years to maintain certification.

In FY 2010, to provide continuing education opportunities for the employees of agencies that provide prevention and treatment services, DBHR is supporting three separate conferences for treatment and prevention professionals. DBHR will support additional trainings through a contract with Office of Superintendent of Public Instruction and through contracted funding with counties and tribes.

The goal is to provide continuing education and training opportunities to **over 1750 professionals** working with clients who are impacted by the affects of substance abuse and dependence or working in the area of prevention. As of August 2010, reporting on the progress for Continuing Education, ***250 participants*** attended the Saying it Out Loud conference in May 2010 and ***56 participants*** attended the Substance Abuse Prevention Specialist Trainings (SAPST). Progress on planning for additional training opportunities is indicated in activities below.

We are committed to sustaining a competent workforce of Chemical Dependency Professionals and Prevention Professionals in Washington State who have the skill set to deliver effective services. With SAPT Block Grants funds dedicated to Continuing Education, Washington State is able to support training of a diverse and competent workforce capable of meeting the needs of substance use involved individuals. To work to assure the delivery of high quality treatment services for youth and adults, and assist in improving the quality of care for individuals and families in need of Chemical Dependency and Prevention Services, DBHR provides Continuing Education opportunities for those working in the field.

The overall outcome for professionals who attend training funded by the SAPT Block Grant is to increase the knowledge and skills of addiction treatment practitioners by disseminating state-of-the-art research and by providing evidence-based workforce continuing education; heighten the awareness, knowledge, and skills of all professionals who can intervene in the lives of people with substance use disorders and continue to foster alliances among practitioners, researchers, policy makers, funders, and consumers to support and implement best treatment practices through cross-disciplinary training at statewide conferences.

Activity 11-1 (Progress)
Co-Occurring Disorders and Treatment Conference

Planning began in 2009 in preparation for the 2010 Co-Occurring Disorders and Treatment conference which will be held October 4-5, 2010 at the Yakima Conference Center in Yakima, WA. Input from stakeholders, evaluations the year previous event, and contracted support through Washington State University, provides guidance and coordination for the agenda, presenters and logistics for this conference.

The theme for this year's conference is entitled "Managing Change: Maintaining Excellence, Turning Crisis into Opportunity." This two day conference provides continuing education to over 600

professionals. Key note speakers for this year's event are Ken Minkoff M.D., Bo Bernhard, Ph. D., Ijeoma Achara, Alton Jamison, and Janice Gabe.

Training tracks for this conference will include presenters addressing issues in the following areas: Aging, Promising /Evidence Based Practice, Legal – Corrections, Developmental Disabilities, Research, Veteran's Issues, Youth Track, Consumer, Medical, Recovery Oriented Systems of Care, Leadership.

Training tracks will provide presentations on programming, research, and the specific treatment needs that are unique to the older adult, youth, Veterans, and clients with developmental disabilities. There will be a separate training track for the Promotion of Evidence-Based Practices. The "Consumer Track" offers workshops on the consumer perspective about recovery. The "Medical Track" at the conference will provide the audience with information on Medication Assisted Treatment; Post Traumatic Stress Disorder; Physical, Chemical Dependency and Mental Health issues with Adolescents. There is also a planned presentation on prescription Opioid issues for treating chronic pain, including recent trends in the use and abuse, and strategies for assessing and monitoring patients on Opioids for pain. The "Recovery-Oriented Systems of Care" Training Track will build awareness in the field of how a recovery-oriented system of care would look in comparison to the current system. On October 6th, the day after the conference, Ethics training will be available to participants.

The training tracks and workshops link to training needs identified in past participant evaluations, data indicated from recent trend reports for Washington State, and input from the planning committee and stakeholders.

Activity 11-2: (Progress)
The Prevention Summit

The *goal* of the Prevention Summit was to provide an enriching training and networking opportunity for youth, volunteers and professionals working toward prevention of substance abuse and violence. The Prevention Summit was held on October 30 and 31, 2009 in Yakima, Washington. The Prevention Summit provided education and training on the prevention of alcohol, tobacco and drug use and placed an emphasis on the importance of the prevention of prescription, and synthetic substance use. Prevention of prescription drug use is of key importance as the annual DBHR Trends Report indicated an increase of youth abusing opiate prescription drugs in our state over the past few years.

DBHR staff with the input from stakeholders, evaluations from previous year's event and contracted support with Center for the Application of Substance Abuse Technologies provided guidance and coordination for the agenda, presenters and logistics for this conference.

For this Summit, 737 participants attended, including 46 youth teams. Out of the 46 youth teams, 25 new prevention teams participated in the Summit. The number of participants is increased from 2008; the fact that attendance increased in light of multiple budget reductions, was encouraging. The Summit draws a diverse audience. Of the participants that identified by race, 39% indicated that they were non-Caucasian. This participation rate is a 34% increase from last year.

For this event there were a total of 31 presenters (including keynotes) with 11 presenters who worked pro bono at the Summit. As part of the Summit, Youth and chaperones donated over 600 hours of service to the Yakima community at the six service project sites.

Participants, volunteers and the Planning Committee reported that overall the Summit was a high quality learning experience. As indicated by survey responses score, participants noted that the conference helped them gain knowledge, the presentation content was relevant and provided useful information, and

the conference was a motivational experience. Of those that completed the survey, 91% of the participants reported that they were "satisfied/ very satisfied" that the conference helped improve professional effectiveness. Additionally of those that completed the survey, 93**%** stated they were "satisfied to very satisfied" that the conference was a motivational experience.

For the 46 youth teams, the Youth Leadership workshops focused not only on the prevention of alcohol or substance use but proposed that each youth team become involved in their own prevention project to be undertaken after the Prevention Summit in the team's school and community. For those Youth Teams that participated in the 2008 Prevention Summit, 42% of the teams went on to complete their proposed Prevention Projects.

The outcomes of the Prevention Summit: participants increased their knowledge of prevention science and practice; the event promoted professional effectiveness through enhancement of partnerships, increased awareness of state issues, and promoted motivation of professionals and youth to continue work for prevention of problem behaviors.

Activity 11-3: (Progress)
Saying it Out Loud Conference

The eleventh annual "Saying it Out Loud Conference" (SIOL) was held on May 19th, 2010 at Shoreline Conference Center in Shoreline, WA. 250 participants attended this one day conference. This conference brought together professionals from the field of Social Work, Mental Health, Chemical Dependency Treatment, and Substance Abuse Prevention to focus on chemical dependency and its impact in the Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) community. Jamie Grant, PhD., Director of Policy Institute, National Gay and Lesbian Task Force was the keynote speaker. Dr. Grant offered two presentations one entitled "Authenticity, Creativity and Health – "What's Addiction Got to Do with it?" and the second "Coming into Voice and Full Empowerment as LGBTQ." Workshops for the day included: Bullying and Intervention Strategies; Challenges and Supports in Counseling LGBTQ Clients (Panel Presentation); Fostering Resiliency in LGBTQ Youth; Honor Project Report – Health Survey of Two Spirited Native Americans – Findings; Put This on The Map – A Film Screening and Post Screening Interactive Workshop.

From the submitted evaluations, the conference received an *overall evaluation score of 4.6* out of a possible high score of 5.0.

Others in attendance for the conference: Susan Dreyfus, DSHS Secretary; David Dickinson, DBHR Director; Frances Carr, Master of Ceremonies, Retired-Director of DSHS Office of Diversity Affairs, who also read Governor Christine Gregoire's Proclamation recognizing June 2010 as LGBT Pride Month. Members of DBHR's Chemical Dependency LGBTQ Technical Advisors Workgroup and the Mental Health Sexual Minority Subcommittee were also in attendance for the conference.

Members of the SIOL Planning Committee included Marsha Botzer, National Gay and Lesbian Task Force; Joseph Connor, Pastor ; David Flack, Center for Human Services; staff from Children's Home Society; representation from King County ; and staff from Econimic Services Administration, Division of Vocational Rehabilitation, Division of Developmental Disabilities and Division of Behavioral Health and Recovery.

Activity 11-4: (Progress)
Substance Abuse Prevention Specialist Training

This comprehensive four day training on the Science and Application of Prevention was offered in three areas in the state; a total of **56 participants** attended these trainings.

The Substance Abuse Prevention Specialist Training (SAPST) is a national curriculum developed by the federal Center for Substance Abuse Prevention (CSAP). The training incorporated lecture and experiential learning on various topics including: Prevention in its Historic Context; Research and Planning; Evaluation; Dimension of Diversity and Cultural Issues; Media (Media Advocacy, Media Literacy and Social Marketing); Human Development and Prevention. For a Certificate of Completion, participants were required to attend all four days of the training. The participants were awarded a certificate for a total of 30 hours. The approved SAPST hours can be used toward the initial application for a Certified Prevention Professional (CPP) credential. These hours may also be used as Continuing Education Hours (CEU's) toward the two-year CPP renewal requirements.

The Seattle training was held April 5-8, 2010 with 26 participants. The lead Seattle trainers were: Bridgette Agpaoa Ryder, MA, Family Counselor and Case Manager of the Family Program at Valley General Hospital. She is an instructor at Seattle Central Community College (SCCC), Health and Human Services Program. Kim Beeson, MSW, Prevention Center Director, Puget Sound Educational Service District (PSESD) Learning, Teaching, and Family Support Department, has completed the SAPST and Substance Abuse Prevention Training of Trainers, and delivered the curriculum to school staff.

The Spokane training was held on May 12-13 and May 19-20, 2010. The Spokane trainers included: Alan Zeuge, MPA, CPP, ICPS, Coordinator, Substance Abuse Prevention, Community Services, Spokane County; Tricia Hughes, MHPA, CPP, ICPS, Student Assistance Program Coordinator, Mentoring Children of Promise, Northeast Washington Educational Service District 101; and Gunthild Sondhi, M.Ed., CPP, ICPS, Consultant/Evaluator.

A SAPST Training for Trainers was held in Ellensburg June 7-10, 2010 with 8 participants. Participants were trained and certified to deliver the SAPST curriculum. Participants were selected on the basis of several factors including but not limited to: having completed the SAPST participant training; levels of prevention and training experience; estimate of the extent that the applicant plans to deliver the SAPST within Washington State. Participants for the Training of Trainers were representative of the broad diversity and geography of Washington State.

Training content included: practice in preparing and delivering the SAPST curriculum, material on interactive training techniques and individual presentations. The lead trainer for "Training of Trainers" was Nora Luna. Ms. Luna is an Area Extension Specialist in School Retention for the University of Nevada Cooperative Extension Southern Area. Previously she served as the Associate Director of the U.S. – Mexico Border Communities Alliance for the Western Center for the Application of Prevention Technologies. Ms. Luna has over ten years of prevention experience, is a Certified Prevention Specialist and has been a staff member of the University of Nevada Reno since 1998. She was the lead in the development of all Western CAPT Spanish products and other materials such as SAPST.

Goal #12: Coordinate Services

An agreement to coordinate prevention activities and treatment services with the provision of other appropriate services (See 42 U.S.C. §300x-28(c) and 45 C.F.R. §96.132(c)).

Note: In addressing this narrative the State may want to discuss activities or initiatives related to the provision of: *Convened work groups/task force/councils; Conduct training/TA; Partnering with association(s)/other agencies; Coordination of prevention and treatment activities; Convening routine meetings; Development of polices for coordination; Convening town hall meetings to raise public awareness; Implementation of evidence-based services.*

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

Goal #12 Coordinated Services
FY 2011 (Intended Use)

DBHR has established a Statewide Coalition to Reduce Underage Drinking (RUaD). The Coalition was formed to ensure cross-system collaboration on this critical public health issue. Sub-committee Impact Teams have been formed to address specific underage drinking issues relating to; alcohol marketing, communications, schools/parents, law and justice. The Coalition is Co-Chaired by DBHR Staff and the Chair of the Washington State Liquor Control Board. The Coalition is comprised of 26 state agencies and statewide organizations (see Washington State Coalition to Reduce Underage Drinking Attachment for complete list of coalition members)

Each Impact Team developed a plan of action for FY 2011 and will meet regularly to execute their plans. The Statewide Coalition will meet on a monthly basis with hosting rotating among state agency members. Executive Leadership from the hosting agency will be invited to provide an agency update each month. A facilitated strategic planning meeting scheduled for September 24, 2011 will set the direction for the future of the RUaD Coalition. National underage drinking experts will provide feedback on the Coalition plans. We have been awarded a Discretionary Grant from Office of Juvenile Justice and Delinquency Prevention (OJJDP) to support the enforcement of Underage Drinking Laws, which will include a technical review of the Coalition activities. This feedback will be used to enhance Coalition efforts for the 2011-13 timeframe.

DBHR staff plan to coordinate the implementation of annual underage drinking prevention town hall meetings in communities throughout Washington. The town hall meetings are part of a national effort to increase understanding and awareness of underage drinking and its consequences, and to encourage individuals, families, and communities to address the problem. These efforts are contingent upon continued funding through the Interagency Coordinating Committee on the Prevention of Underage Drinking**.**

(Activity 12.2)

We will convenes and facilitate the Washington Interagency Network (WIN) on Substance Abuse Issues. The WIN Group (see WIN Roster attachment for complete listing of WIN membership) was established as a forum for state agency managers to share information on alcohol, tobacco and other drug issues. The Network spends considerable time on policy issues throughout the state legislative session, while focusing more on program design and implementation issues during off-session months. During the legislative session, WIN will meet weekly to review proposed substance abuse related legislation, and potential impacts for the substance abuse prevention and chemical dependency treatment field. During off-session months, WIN will continue to meet, monthly, to ensure program coordination and collaboration.

The WIN Group intends to work on the implementation of the SPF/SIG developed State Prevention Plan in the 2011-13 timeframe. The key elements of the plan include; Workforce Development, Common Outcome Measures, Evidence-based Practice, Prevention Planning, and Public Information. This plan was developed by SPF/SIG Staff under the direction of the SPF/SIG Advisory Committee which included all of the active WIN Prevention Members. The plan sets a framework for cross-system state agency collaborations and coordinated efforts at the community level. Over 200 prevention professionals in Washington State provided input into the plan at community meetings and via electronic surveying techniques.

(Activity 12.3)

The contracts between DBHR and county governments contain language that required a 6-year strategic plan for prevention, intervention, treatment and aftercare/support services. The planning guidelines included stakeholder recommendations for counties to include in their community-based planning process (see Recruitment Directory attachment for listing of recommending collaboration partners.) We are currently beginning year four of the 6 year plan. It is expected that counties would reconvene their stakeholder groups when update their plans as new data becomes available. It is also expected that the education sector will play a significant role in county planning for prevention services in 2011-13. We are currently engaged in a collaborative process to re-design how prevention services are planned at the community level. This re-design process will continue through 2011-13 will ensure that school and community-based prevention services, funded by DBHR, are coordinated at the local community-level.

(Activity 12.4)

DBHR will be working throughout the 2011-13 time period to coordinate substance abuse prevention and mental health promotion services where feasible. We will also be working to maximize the coordination and integration of substance abuse and mental health treatment services. There is also a focused effort currently underway to develop strategies that would coordinate and integrate behavioral health and primary health care services by leveraging National Health Care Reform.

To date these efforts have included plans to: Integrate Administrative Codes relating to chemical dependency and mental health treatment; Survey providers to find out which Chemical Dependency Treatment providers also offer Mental Health services; and, incorporate training on Mental Health Promotion and Treatment practices into existing substance prevention and treatment workforce development trainings. This information will inform planning and program decisions made throughout 2011-13.

(Activity 12.5)

DBHR prevention services FY2011-2013 contracts with county governments will continue to emphasize the Department's commitment to the implementation of evidence-based practices. County contracts will have dedicated funds for training related to the implementation of evidence based prevention practices. The contract language will read:

Community Prevention Training System – Special Funding Requirements

The County receiving prevention training funds allocation based on its current "Counties Like Us" classifications in the Risk and Prevention Profile for Substance Abuse Prevention identified on the SRP for the Community Prevention Training System (CPTS) shall:

a) Ensure the CPTS training allocation is used solely for training opportunities that will increase county capacity to implement science-based substance abuse prevention programming as negotiated with their Regional Administrator.
b) Ensure the training allocation is used to support the county's stated goals and objectives as identified in their needs assessment process.
c) Ensure prevention services subcontractors are effectively trained to implement the programs they agree to provide.
d) Ensure the training allocation is used to support training of staff or subcontractors in Best Practices or Promising Approaches (evidence-based programs) or practices, or to increase capacity to implement Best Practices or Promising Approaches (evidence-based programs). "Increasing capacity" means activities like grant writing training, board training, and community organizing or volunteer recruitment training.

e) Collaborate with other Counties whenever possible in the planning of local or regional training events.
f) Report training events in the DSHS Performance Based Prevention System.
g) Ensure training funds are not used to support employee wages or benefits, or program implementation.
h) Ensure that training that requires travel follows state travel reimbursement guidelines accessible at: http://www.ofm.wa.gov/policy/10.90.htm .

County contracts will specify that at least 50% of prevention programs implemented must be evidence-based practices. The contract requirement will read:

> Ensure fifty percent of programs supported by DSHS funds will be replication or adaptation of "Best Practices" substance abuse prevention programs as identified on the Western Center for the Application of Prevention Technologies (WCAPT) website or its replacement.

(Activity 12.6)

DBHR will continue to fund Substance Abuse Prevention Specialist Training (SAPST) in an effort to provide professional development opportunities in the prevention field. Trainings will be offered several times throughout the year and in various sites statewide.

DBHR, in partnership with other state agencies and non-profits, will organize the annual Statewide Prevention Summit to be held each October in 2011-13. The Statewide Prevention Summit will continue to provide training opportunities to professionals and volunteers, with a separate track for youth. A Chemical Dependency Professional in Washington State as well as for National Association of Alcoholism and Drug Abuse Counselors (NAADAC) will receive 12 continuing education credits for attending the Prevention Summit.

Goal 12 Coordinated Services
FFY 2008 (Compliance)

Activity 12-1 (Compliance):

All Division of Behavioral Health and Recovery (DBHR) county/tribal contracts contained language that required prevention and treatment service providers to coordinate service delivery with other appropriate program and community services to ensure comprehensive client services.

The contractual requirement for collaboration with other systems was as follows:

Collaboration with other Systems:

(1) The County shall take the initiative to work with other systems, examples below, to reduce fragmentation or duplication and to strengthen working relationships by addressing at least one substance abuse system issue or a collaborative effort mutually identified by the County and a respective system.
   (a) Regarding treatment issues or efforts, examples of such systems are criminal justice, corrections, juvenile rehabilitation, mental health, child protection and welfare, adult protection and welfare, and primary health care plans.
   (b) Regarding prevention issues or efforts, examples of such systems are education, juvenile justice, and other publicly-funded entities promoting substance abuse prevention.

During this timeframe, Counties provided a "System Collaboration Report" identifying services and activities performed against this Program Agreement to the DBHR Regional Administrators. In addition, every quarter Counties provided DBHR Regional Prevention Managers a "Community Coordination Report" which identified their local community coordination efforts through the Performance-based Prevention System.

Activity 12-2 (Compliance):
We have coordinated prevention efforts, training, and contract requirements with the Department of Health; Office of Superintendent of Public Instruction; Department of Community, Trade, and Economic Development; Liquor Control Board; and Washington Traffic Safety Commission. To make this coordination successful, representation from all above agencies participated in interagency meetings. These meetings promoted efficient and quality based community programs. The outcome of these meetings: coordination efforts resulted in joint training and conferencing, a cross system needs assessment, and the development of cross-agency grant applications. During this timeframe, a revision of the 18 outcome objectives contained in the Memorandum of Agreement originally drafted in 2002 with the Superintendent of Public Instruction, the Governor's Council on Substance Abuse, the Family Policy Council, Office of Financial Management, the Liquor Control Board, Department of Health, Washington State Traffic Commission, Governor's Juvenile Justice Advisory Committee was completed and a progress report regarding efforts towards those objectives was submitted to the Governor's Council on Substance Abuse.

Goal #12 Coordinated Services
FY 2010 (Progress)

Activity 12.1
The statewide Coalition to Reduce Underage Drinking and its impact teams have made progress in their mission to ensure cross-system collaboration on this critical public health issue. Action plans (for calendar year 2010) specific to underage drinking issues are being addressed in the following areas: alcohol marketing, public policy, communications, schools/parents, and law and justice. The Statewide Coalition meets on a monthly basis with hosting rotating among state agency members. The hosting agency executive leadership is invited to provide an agency update.

Additionally, DBHR staff coordinated implementation of underage drinking prevention town hall meetings in 46 communities throughout Washington in February, March, April, and May. 1,986 adults and 1,518 youth attended the town hall meetings as part of a national effort to increase understanding and awareness of underage drinking and its consequences, and to encourage individuals, families, and communities to address the problem.

Activity 12.2
DBHR has convened and facilitated the Washington Interagency Network (WIN) on Substance Abuse Issues.

The purpose of the WIN Group is to provide a forum for state agency managers to share information on alcohol, tobacco and other drug issues. The Network spends considerable time on policy issues throughout the state legislative session (January – April), while focusing more on program design and implementation issues during off-session months.

The Washington Interagency Network (WIN) meets monthly in Olympia. During the 2010 legislative session, the WIN Group increased its schedule to weekly meetings for 9 weeks in order to discuss bills proposed that have an impact on substance abuse prevention and chemical dependency treatment.

Activity 12.3
The DBHR contracts with county governments contain language that requires a 6 year strategic plan for prevention, intervention, treatment and aftercare/support services. The planning guidelines included stakeholder recommendations for counties to incorporate in their community-based planning process. Currently, the county governments are in year five of their six year strategic plans. In order to keep their plans viable, many counties will use the latest Healthy Youth Survey data, local and state data and reconvene their stakeholder groups to make necessary revisions to their Strategic Plans.

Implementation of the 6-year strategic plan prioritized the implementation of evidence-based services. County contracts specify that at least 50% of prevention programs implemented must be evidence-based practices. The contract requirement reads:

a) Ensure fifty percent of programs supported by DSHS funds will be replication or adaptation of "Best Practices" substance abuse prevention programs as identified on the Western Center for the Application of Prevention Technologies (WCAPT) website or its replacement.

To date in FFY2010, all counties meet or exceed the 50% expectation. Statewide, 73% of programs implemented are evidence-based.

To support the implementation of evidence-based practices, prevention service contracts with the county governments specify dedicated funds for trainings related to the implementation of evidence based prevention practices.

Activity 12.4
In an effort to review current service linkages and provide better coordination of services for youth in the prevention, intervention and treatment of substance use disorders, DBHR convened a meeting in Olympia with representation from the Office of Superintendent of Public Instruction, Directors of Student Assistance Programs through Educational Service Districts, County Coordinators, youth outpatient and youth residential providers. This meeting occurred in early August. The purpose of this meeting is to share information about current service structures such as referral sources, programs available, to review data related to care coordination between levels of care and note any changes in current service infrastructure due to policy changes, fiscal impacts or clinical improvements in programming. The outcome of this meeting is to identify both areas of success and impeding system barriers and to identify work to systemically improve coordination between multiple supports for youth in Washington State.

Goal #13: Assessment of Need

An agreement to submit an assessment of the need for both treatment and prevention in the State for authorized activities, both by locality and by the State in general (See 42 U.S.C. §300x-29 and 45 C.F.R. §96.133).

Note: In addressing this narrative the State may want to discuss activities or initiatives related to the provision of: *Data-based planning; Statewide surveys; Youth survey(s); Archival/social indicator data; Data work groups; Risk and protective factors Household survey data utilization; Prioritization of services; Provider surveys; Online surveys/Web-based reporting systems; Site visits.*

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

Goal #13 Assessment of Need
FFY 2011 Intended Use

The Division of Behavioral Health and Recovery (DBHR) will refine and expand the needs assessment for substance abuse prevention, intervention and treatment to more comprehensively focus on sub-county planning areas and to determine what services should be prioritized in sub-county areas based on the assessment. Decisions to allocate resources will be balanced by considerations of workforce and provider capacity. Finally, policy considerations---for instance, strategic priorities and legislative mandates---will be incorporated into the assessment.

The needs assessment process will evolve differently for treatment/recovery support and for prevention. In each case, the State Epidemiology and Outcomes Workgroup[1] (SEOW) will assess existing data; recommend how each source will be used; and, base recommendations on those data. We intend that future resource allocation decisions will be more directly related to epidemiology profiles using data from the National Survey of Drug Use and Health, SAMHSA's State Epidemiological Data System (SEDS)), surveys conducted in the state (the Healthy Youth Survey and Washington's implementation of the Behavioral Risk Factor Surveillance System (BRFSS))), indicators from DSHS administrative data (the Integrated Client Database), and archival/social indicator data in our Community Outcomes and Risk Evaluation Geographic Information System(CORE-GIS). Using data from a wide variety of state and national reporting systems, the CORE GIS includes state, county, and local epidemiological profiles derived from the risk/protective factors framework. Using the CORE GIS and address-level client service data, we will be able to target sub-county planning areas. The evaluation of the data analyses typically occur in several data work groups, and with an informal data monitoring system. The existing State Epidemiological Outcomes Workgroup will formalize this monitoring activity, examining all data on a regularly scheduled basis. This work group will also make recommendations as to new indicators and analyses for strengthening the profiles. The Data/Analytic Workgroup meets biweekly to discuss how to improve DBHR's data quality, data timeliness, and data reporting. A Systems Improvement Workgroup (with providers, counties, and staff) looks for ways to better use performance and outcome data, specifically regarding the Treatment Analyzer, an online web-based reporting tool that allows user generated ad hoc reports.

DBHR is pursuing several avenues for identifying gaps between services delivered and the need for services. Complex estimation procedures are being developed to identify the need for treatment among people who have not already received services and are therefore not in the data system. Following another avenue of exploration, providers have been informally surveyed about capacity and wait lists to determine if service gaps were related to capacity. Wait list data are now collected formally in the treatment data system, TARGET. In the prevention system this approach does not work because we individual client data is not collected; therefore, the SEOW will make recommendations as to what criteria should be used to identify the need for prevention services, including epidemiological profiles of risk factor "pile ups".

Task 13.1
The **needs assessment for treatment and recovery** will proceed step-wise, and will conclude with funding recommendations:

1. Identify the people who are eligible for publicly funded services and who need chemical dependency intervention, treatment, and/or recovery support services.

[1] The State Epidemiology and Outcomes Workgroup is made up of researchers and epidemiologists from multiple State agencies tasked with monitoring and improving the health and outcomes of the population, as well as university researchers working in the substance abuse field.

2. Determine how many of those individuals previously received (or are currently receiving) services.
3. Calculate the "unmet need" or "treatment gap" as the difference between those who need services and those who received services.
4. Finally, allocate funding according to the overall rate of need, and adjust to increase funding in areas of significant unmet need among youth (who are more expensive to treat) and underserved populations.

DBHR will implement new analytic procedures to complete a more finely detailed needs assessment. Starting with the National Survey on Drug Use and Health (NSDUH; OAS, 2010), although the NSDUH is not sufficiently detailed to allow sub-state geographic analyses or sub-population specific analyses. To develop sub-population estimates from the state level NSDUH. We will implement a newly developed methodology for estimating chemical dependency treatment need, among existing the Department of Social and Health Services clients using DSHS administrative data(Sears et al, 2010). We recognize that it is likely that this estimate significantly and non-randomly undercounts the true population in need of treatment. For instance, those clients who have had difficulty or reluctance to engage with DSHS in the past are not counted (e.g., emancipated minors, single men with no children and without insurance, members of certain ethnic/cultural groups). Also, despite data/analytic efforts, depending on the "entrance" to DSHS, some individuals might not be screened for substance use disorders and thus would not be flagged as being in need of treatment. To resolve this undercount, NSDUH will be used to state estimates of the prevalence of alcohol and drug dependence. We will utilize a synthetic estimation process to determine treatment need within sub-state demographic and geographic groups.

To ascertain which people need treatment and might be eligible for publicly funded services requires detailed knowledge of the poverty rate among demographic groups, but, in Washington, this currently does not exist at the geographic scale at which funding allocations are made. The State's Office of Financial Management regularly updates projections of county populations by age, sex, race, and ethnicity. Based on those projections, op a methodology will be developed that employs the American Community Survey information including poverty and health insurance rates (by PUMA) to estimate treatment need by county and demographic group. We will work to have the same methodology adopted by other state agencies to support sustained, consistent needs assessments.

Task 13.2
The second major concern is that the current funding allocation is based primarily on historical funding levels. A funding formula was created in the past, based on population and existing treatment counts; however, the formula has not been updated in nearly 10 years and the current funding, given severe economic stressors, is based on prior year funding. The needs assessment process will adjust these allocations based on updated population and need data, with further enhancements based on specific unmet needs: people who are not DSHS clients, but are eligible for publicly funded treatment; those members of chronically underserved populations; and those populations identified as high risk. This will involve the use of estimation procedures described above, as well as analyses of archival and survey data that will be presented in sub-population level profiles developed by the SEOW.

As work is done to refine the funding allocations, several issues must be taken into consideration: 1) in Washington, the average cost to treat an adolescent is considerably more than the cost to treat an adult and this needs to be considered in any funding formula; 2) counties with significant unmet need for underserved populations must receive supplemental funding, beyond the average cost per person in need; and, 3), other significant disparities will be identified and added as factors in funding allocations as work is done with the SEOW. The reallocation of funding is likely to be challenging in tough economic times, and we will work with our stakeholders to increase support for these efforts.

Task 13.3
To refine the **needs assessment for AOD prevention**, we plan to proceed in a parallel fashion (step-wise, based on data, with the identification of underserved and high need populations). The data sources and assumptions for prevention present different opportunities and challenges. Needs assessment of Alcohol and Other Drug (AOD) prevention for children and youth will be based on the state's Healthy Youth Survey (HYS), which is administered biennially in more than eighty percent of schools. The survey includes a complete set of substance use indicators, risk and protective factors for substance use, as well as data on problem behaviors associated with substance use.

The epidemiological considerations of the adolescent substance use indicators point to prevention strategies that target specific problems and risk factors, and those can be grouped according to the Institute of Medicine's universal/select/indicated. Some of the services, for instance school-based curricula delivered in health classrooms, are intended for universal audiences---that is, in the example of the health curriculum, all the students in the school or classroom. For more select populations, in the IOM category "select", a group of people who are known to be at higher risk, strategies or programs are delivered for an audience that is specifically recruited to the program. For youth identified as already involved in a problem behavior, services are specific and indicated (as in the IOM category). Our needs assessment will refine youth substance use indicators so as to highlight areas of high need by the level of substance use involvement.

Some of our new state priorities have been prompted by findings of the HYS. For instance, after assessing non-quantitative surveillance information, in 2006 we developed and added a question on the use of prescription opiates, and in 2008 added a question about the source of those drugs. Major state initiatives have been based on HYS data. For instance, in developing the Washington State Strategic Prevention Framework State Incentive Grant project, the State Epidemiological Outcomes Workgroup (SEOW) used HYS data and published reports on costs to society, to determine that the state's prevention priority would be underage drinking. Using the school-level data we identified all of the schools in the state where the drinking level of 8th graders was at least a standard deviation above the state average. Starting with the extensive demographic data included in the HYS, the SEOW will estimate the need for prevention services in those populations that do not participate in the survey. For instance, private schools, schools on Indian lands, and several school districts with concentrations of low socio-economic status populations have not participated on a regular basis. In addition, we have no way of surveying youth who have dropped out of school. The estimation process will address this disparity. For instance, from the HYS data we will know the rate of substance use among Hispanic youth living in rural counties, and will extrapolate those rates to Hispanic populations in rural school districts that do *not* participate in the survey. The needs assessment will include a prioritization approach approved by the SEOW that balances the need for prevention among DSHS clients (those in high poverty neighborhoods or among high risk population groups) and the cost to the state of behaviors associated with youth substance use.

Task 13.4
The **assessment of need for youth intervention services** will be based on the Healthy Youth Survey data. Those intervention services that are best located in schools can be placed according to high rates of substance use and associated problem behaviors, as measured by the survey. But the needs assessment also will be enhanced by incorporating information on the distribution of high risk associated with families of substance abusers and neighborhoods of high poverty or high density of DSHS clients. Prevention and intervention with young adult populations present special challenges. A literature review supported by the epidemiology workgroup has identified risk factors associated with different subpopulations of young adults. However, neither of the extant sources of data (the NSDUH and the Behavioral Risk Factor and Surveillance System (BRFSS), have adequate data for this age group to help us allocate resources accordingly. The SEOW had recommended an expansion of our data collection using the BRFSS and we will consider identifying funding to allow this expansion.

Task 13.5
As part of a prevention system redesign, we will work with counties to complete needs assessments that are more rigorous and comprehensive for community level planning. The pilot of this redesign will likely include about 10-13 counties, that will each work in specific high need communities. Within those communities, a wide ranging needs assessment will identify problem behavioral outcomes, and the risk factors that predict them in the community and environmental domain, in the school domain, and in the family and individual/peer domain. These data will come from the HYS and the CORE GIS. Additional data will be collected locally, including a survey of the availability and capacity of service providers, and outcome indicators that are not available in state databases.

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Goal 13 - Needs Assessment
FY2008 Compliance

Activity 13.1
The Division of Behavioral Health and Recovery (DBHR) worked with partner agencies to improve the on-going delivery of data to use for needs assessments. First, the DSHS office of Research and Data Analysis provided substance use profiles and risk factor profiles based on archival data. These profiles were made more user-friendly and were up-dated at six-month intervals during the reporting period. DBHR worked with the Office of the Superintendent of Public Instruction and the Department of Health to improve the scope of survey data collected on the biannual Healthy Youth Survey. With these partner agencies we analyzed and then delivered adolescent substance use and problem behavior outcome data, along with profiles of risk and protective factors.

Activity 13.2
County contractors were required to develop a local needs assessment upon which their spending plans were based. The needs assessment guidelines laid out concretely the people who were required to participate in the assessment, and suggested sources of data. Following other components of the guidelines, contractors discussed in their needs assessment narrative how they would address the needs of specific sub-populations: ethnic minorities, sexual minorities, underserved populations, rural communities, and others.

Regarding the needs assessment for treatment services, county contractors assessed their existing services, and explained how they would fill the gap between needs and services, for the general population and for specific sub-populations. Contractors compared their last biennium service levels to those they would achieve to match the identified gaps, and to address DASA's (DBHR's) major cost centers (i.e., Community outreach, intervention, referral; HIV/IVDU outreach and referral; crisis services; detoxification services; involuntary commitment; ADATSA assessment; ADATSA outpatient; general outpatient; outpatient for the PPW population; and drug courts and criminal justice services). County needs assessment and service plans are available upon request.

Prevention needs assessments were written in support of new county prevention plan. That plan addressed the risk and protective factors identified in the needs assessment, with goals and objectives tied to results of the assessment. The plans included target populations and specific outcomes related to prevention services for that population. Those outcomes were matched to evidence based prevention practices as identified on the website maintained by the Western Center for the Application of Prevention Technology. DASA (DBHR) required that county contractors select at least fifty percent of their prevention services from that listing of Best Practices and/or Promising Approaches; in fact 71 % of prevention services provided were EBPs.

As part of the prevention county contracts, training services were made available to ensure high quality of implementation of prevention services and to enhance the counties'capacity to deliver prevention services. Most counties designated a prevention county coordinator who planned and sometimes delivered these services, worked to increase capacity, and developed collaborative relationships with other service providers. The county coordinator (or a subcontractor designated to perform these services) took responsibility for ensuring the timely reporting of prevention services data into DASA's (DBHR's) Performance Based Prevention System. At the beginning of this reporting period, counties were only completing data entry 70% on-time reporting. In an effort to improve on reporting compliance, monthly updates by County were distributed to field staff to identify opportunities for technical assistance or corrective action. As a result, monthly compliance rose to over 90% giving the state an 87% annual compliance. At this point, all counties have completed data reporting for 2008.

Goal #13 Assessment of Need
FFY 2010 Progress

In 2010 The Division of Behavioral Health and Recovery (DBHR) has been developing greater accessibility to and interpretation of two major sources of Needs Assessment data, the Healthy Youth Survey (HYS), and the social indicator database, Community Outcomes and Risk Evaluation Geographic Information System (CORE-GIS). Guiding this process, our State Epidemiology Workgroup is balancing the use of existing administrative data with efforts to acquire new sources of data, for instance by expanding our participation in the BRFSS. The efforts will support better County and sub-county needs assessment.

For the Healthy Youth Survey (HYS), working with our interagency planning committee, we have created and begun distribution of a fact sheet that explains the survey content and various features of its on-line version, to increase use of the data. We also developed a users' guide for the ad hoc query system that is part of the online website. We are working with our contract partner to map HYS results, and we have some samples developed for use internally, as a first step. For the Community Outcomes and Risk Evaluation Geographic Information System (CORE GIS) we are working on an interface to allow greater flexibility in report generation. Our mapping capacity is challenged by the large amount of data that are available for mapping, so mapping is only performed on an ad hoc basis until we complete design of a query system. Finally, a new two-page fact sheet that outlines features of the CORE GIS is being distributed widely.

To date we have not developed new training venues as new data reporting projects are still in the development stage.

Recruiting for the 2010 HYS was the major activity of the first half of 2010. More than 80% of the school districts have registered for the survey. We are increasingly concerned about the CDC's requirements for grantees to implement the YRBS, which competes with the HYS, and around which our collaboration with the Washington State Department of Health and the Office of the Superintendent of Public Instruction has spent years in negotiation to avoid conflict. We are working to establish sustained funding for HYS for the 2012 implementation and beyond, by demonstrating the utility of the survey and reports to other agencies and by presenting information to external foundations that have an interest in the health of children in the state of Washington.

The State Epidemiology Work Group has been meeting to prioritize needs assessment data. The group has focused on improving the process, with only modest additions of new data elements. Specifically, the group is considering new estimation procedures to extrapolate state levels of sub-population substance use rates to sub-state geographies. We are also working across agencies to develop sub-state geographic forecasting data that can be used for multiple state agencies. These procedures are working well for DSHS clients. A new procedure that incorporates American Community Survey data will improve the process to assess the needs of people who are not in our administrative data. We expect the results of these efforts to guide county-level needs assessments beginning in FY2011.

The county contracts are revised to address some changes in approach, particularly in the collection of outcome data. Due to significant budget impacts, the counties were permitted to delay updating the Strategic Plan, but this remains a key focus of the Division. We are working on a new approach to needs assessment for counties that are willing to focus on sub-county communities. DBHR, with the SEOW, is looking at how needs assessment data will have to be revised to focus on populations not previously highlighted in our major data sources.

The BRFSS data from the 2009 implementation are available, which gave us access to more information on alcohol and marijuana, as well as non-medical use of prescription medications (all targets of state efforts), but the low percentage of young adults in the database is disappointing. This is due to the difficulty of including cell phone users in a telephone survey, and so the group is considering alternative strategies moving forward.

Goal #14: Hypodermic Needle Program

An agreement to ensure that no program funded through the Block Grant will use funds to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs (See 42 U.S.C. §300x-31(a)(1)(F) and 45 C.F.R. §96.135(a)(6)).

Note: In addressing this narrative the State may want to discuss activities or initiatives related to the provision of: *Prohibitions written into provider contracts; Compliance site visits; Peer reviews; Training/TA.*

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

Goal #14 Hypodermic Needle Program
2011-2013 Intended Use

All publically-funded contracts, for SFYs 2011-2013, with the Division of Behavioral Health and Recovery (DBHR) that are allocated SAPT Block Grant funds will include language that funds cannot be used to provide individuals with hypodermic needles or syringes.

DBHR contract managers will review each County subcontractor boilerplate contract. This will ensure that similar language regarding restriction on the use of the SAPT Block Grant funds regarding hypodermic needles or syringes is incorporated into subcontracts. DBHR contract managers will conduct on-site reviews on all contractors at least once during the 2-year contract period. County Coordinators will be responsible to monitor and provide technical assistance and training to their subcontractors within their respective counties and report to DBHR any noncompliance issues

Goal 14- Hypodermic Needles
FFY2008 Compliance

Prohibitions of the SAPT Block Grant funds were written into county and tribal contracts which included a statement that funds will not be used to provide individuals with hypodermic needles or syringes. It stated:

> The following costs are considered unallowable uses of SAPT Block grant funds for Agreements and for any subcontracts that use SAPT Block Grant funding:
>
> > Carrying out any program of distributing sterile needles for the hypodermic injection of any illegal drug, or distributing bleach for the purpose of cleansing needles for such hypodermic injection

In addition, each contractor who chose to subcontract was responsible to ensure similar language was carried forward. DBHR Regional Administrators reviewed County boilerplate subcontracts to ensure that all appropriate block grant requirements were included, including the prohibition of funds for hypodermic needles or syringes.

During the biennial on-site review of each county or tribal contract, the DBHR would again confirm that language was included in subcontracts and that counties ensured compliance. No contract was found out of compliance with this requirement.

County Coordinators, who had subcontractors, were responsible for monitoring and providing technical assistance to their subcontractors and report to DBHR any noncompliance issues. There have been no compliance issues.

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Goal #14 Hypodermic Needle Program
2010 Progress

DBHR has language in all contracts that SAPT Block Grant funds will not be used to provide individuals with hypodermic needles or syringes.

The following contract language is included in the 2009-2011 contracts:

> The following costs are considered Unallowable Uses of SAPT Block grant funds for Agreements and for any subcontracts that use SAPT Block Grant funding:
>
> > Carrying out any program of distributing sterile needles for the hypodermic injection of any illegal drug, or distributing bleach for the purpose of cleansing needles for such hypodermic injection

At the beginning of the biennium (July 2009) DBHR Regional Administrators reviewed each County subcontractor boilerplate contract to ensure that similar prohibition language regarding the SAPT Block Grant funds was included. As DBHR Regional staff conducts on-site reviews of the county and tribal contractors they have confirmed the additional language has been incorporated into subcontract.

County Coordinators monitor and provide technical assistance to the subcontractors within their respective counties and report to DBHR any noncompliance issues. As of August 2010, all contractors have been in compliance.

Goal #15: Independent Peer Review

An agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers that receive funds from the block grant (See 42 U.S.C. §300x-53(a) and 45 C.F.R. §96.136).

Note: In addressing this narrative the State may want to discuss activities or initiatives related to the provision of: *Peer review process and/or protocols; Quality control/quality improvement activities; Review of treatment planning reviews; Review of assessment process; Review of admission process; Review of discharge process; achieving CARF/JCAHO/(etc) accreditation.*

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

Goal #15 Independent Peer Review
FY2011 – 2013 Intended Use

The Division of Behavioral Health and Recovery (DBHR), formerly Division of Alcohol and Substance Abuse, has been significantly affected by the financial constraints placed on programs throughout the state of Washington.

The 2010 legislative session resulted in the elimination of certain boards and commissions which included the Citizens Advisory Council on Alcoholism and Drug Addiction (CAC).

Efforts will continue in establishing an ad hoc committee comprised of citizens who represent the voices of their constituencies and regions from which they are appointed. This committee will help develop rules and policies governing prevention and treatment programs in collaboration with department staff, local government and administrators of treatment and prevention programs.

DBHR will plan to utilize the expertise of the ad hoc members to be the oversight body to facilitate the peer review process which include providing recommendations to the DBHR Director**.**

Goal 15-Peer Review
2008 Compliance

Activity15-1:

The annual peer review of 5% of the treatment providers who receive funding is overseen by the Citizens Advisory Council on Alcoholism and Drug Addiction (CAC). The CAC was established under the Revised Code of Washington 70.96A.070, enacted in 1972. The CAC are volunteer advocates who advise and recommend to the Department of Social and Health Services rules, policies, and programs that will benefit individuals and their families with alcoholism/addictions, families and individuals in high-risk environments, and the larger community. The CAC ha a continuing interest in ensuring there is a full array of quality prevention, intervention, treatment, and aftercare services available to address alcohol and drug abuse and addiction, and problem gambling.

The CAC volunteered to take on the responsibility of coordinating the peer review process. This included both recruitment of peer reviewers and providers, and the evaluation of outcomes. A report, developed as a result of the compilation of reviews, was submitted to the DBHR Director. This report included strengths and weaknesses in the treatment system; as well as, recommendations to consider for improvement.

Most reviewers attended a day long debrief session on May 30, 2007 chaired by the PCRSC Chair. Each team had previously submitted a report of their peer review experience. After presenting each of the eight programs reviewed, the chair and reviewers discussed ways to improve the process. Further discussions occurred between the chair and the DBHR staff assigned to the process.

Agencies in the 2008 review served very diverse populations. While five programs served all comers regardless of age, gender, culture, or race, the three were specifically geared to the needs of youth. Of the three programs, two focused on services for Hispanic youth.

The reviewed agencies served between 15 and 300 clients per month depending on modality and size. The program with the smallest treatment population was a residential facility and largest caseloads came from a treatment system within an educational service district covering four counties. Program staff sizes ranged from three to 29 program and administrative staff.

The correlation between the racial makeup of clients and the racial makeup of the agency staff and boards varied among the review agencies. In 2008, 80% of treatment clients were Caucasian, 6% Native Americans, 6% Hispanics, 5% African Americans, 2% Asian Pacific Islanders and 1% “Other”.

The report noted a trend of providers was considering the role of harm reduction techniques in moving patients toward an ultimate goal of sobriety. Many programs were choosing to continue to work with patients who are unable to remain abstinent rather than discharging them for rule violations. To accomplish this, programs were using aspects of the “Stages of Change” model to engage patients at the point they are at in their recovery rather than setting high and perhaps, unrealistic bars for admission.

The report also indicated that programs were seeking ways to increase efficiency, and to integrate technology into treatment. Patients, especially youth, with co-occurring mental

health disorders often did not have access to mental health assessments, counseling, or medication management. Clean-and-sober housing resources were in short supply, both for individuals in outpatient treatment, and patients returning to their communities after residential treatment. There was a need to reduce wait-times and to better prepare patients for the delay in treatment entry. Finally, programs noted a need for more research on best practices effectively treating adolescents.

The state's economic crisis resulted in some budget reductions that impacted programs and processes. Efforts to address the concerns fully, as presented by the peer reviewers, were not able to be addressed. However, results were shared with Counties, Tribes, and treatment providers so strategies could be developed at the local level.

Activity 15.2

Language was included in all contracts to inform contractors about the requirement of participating in Peer Review.

The contract read:

a. Peer Review Required

   The SAPT Block Grant requires annual peer reviews by individuals with expertise in the field of drug abuse treatment, of at least five percent of treatment providers. The County and subcontractors shall participate in the peer review process when requested by DSHS.

Regional Administrators reviewed the boilerplate for county subcontracts to ensure that similar language was included, as well as other Block Grant requirements. The Regional Administrator approved subcontracts when all appropriate language was included.

Goal #15 Independent Peer Review
FY2010 – Progress

The Division of Behavioral Health and Recovery (DBHR), formerly the Division of Alcohol and Substance Abuse, has been significantly affected by the financial constraints placed on programs throughout the state of Washington.

DBHR had been planning to continue to use the chemical dependency expertise of the Citizens Advisory Council on Alcoholism and Drug Addiction (CAC) as the oversight body to facilitate the peer review process which included providing recommendations to the DBHR Director**.** The CAC has been integral in conducting the peer review and advising the DBHR on ways to improve access to services for prevention, treatment, intervention, and aftercare. Unfortunately, the 2010 legislative session resulted in the elimination of many boards and commissions to include the CAC.

A plan is being developed to partner with an independent Mental Health Advisory group to establish a subcommittee within the Mental Health Planning and Advisory Council to continue the CAC activities including the Peer Review process.

Independent Peer Review (formerly Attachment H)

(See 45 C.F.R. §96.122(f)(3)(v))

In **up to three pages** provide a description of the State's procedures and activities undertaken to comply with the requirement to conduct independent peer review during FY 2009 (See 42 U.S.C. §300x-53(a)(1) and 45 C.F.R. §96.136).

Examples of **procedures** may include, but not be limited to:

• the role of the Single State Agency (SSA) for substance abuse prevention activities and treatment services in the development of operational procedures implementing independent peer review;

• the role of the State Medical Director for Substance Abuse Services in the development of such procedures;

• the role of the independent peer reviewers; and

• the role of the entity(ies) reviewed.

Examples of **activities** may include, but not be limited to:

• the number of entities reviewed during the applicable fiscal year ;

• technical assistance made available to the entity(ies) reviewed; and

• technical assistance made available to the reviewers, if applicable.

Independent Peer Review, FY2009

The Revised Code of Washington (RCW) 70.96A.070 established the Citizens Advisory Council on Alcoholism and Drug Additions (CAC). Members are volunteer advocates who advise and make recommendations to the Division of Behavioral Health (DBHR) on rules, policies, and programs that benefit individuals and their families with alcoholism/addictions, families and individuals in high-risk environments, and the larger community.

The CAC also ensured there was a full array of quality prevention, intervention, treatment, and aftercare services available to address alcohol and drug abuse/dependence, and problem gambling.

Because the peer review process needed to be independent and separate from the SSA (DBHR), the CAC volunteered to facilitate and oversee the process. This included sending application materials to all certified substance abuse treatment entities and substance abuse professional organizations in Washington State to invite participation in the peer review process. A similar letter was sent to all Certified Chemical Dependency Counselors (CDPs) in the field inviting them to be reviewers.

For FY2009, eight agencies needed to be reviewed to meet the SAPT mandated five percent. The CAC selected an additional five agencies. The remaining entities were selected from a randomized list with the deliberate intent of finding programs that complimented the volunteer agencies in terms of geography, population served, service constellation and rural vs. urban settings. Agencies that had been reviewed during the previous five years were excluded from the 2009 review.

Nine individuals, with a variety of treatment expertise, volunteered to participate as peer reviewers. Teams of two were selected to review each participating agency. Whenever possible, new reviewers were matched with experienced reviewers. All reviewers signed a disclaimer verifying no conflict of interest in reviewing their assigned agency. Reviewers examined:

- Admission criteria/intake process;
- Assessments;
- Treatment planning;
- Documentation of implementation of treatment services;
- Discharge and continuing care planning; and
- Indications of treatment outcomes.

Each reviewer received at least 8 continuing education credits. The division reimbursed reviewers for peer review-related travel, lodging, and meal expenses.

PEER REVIEWER TRAINING

The reviewers attended a day-long training, that included topics such as: scheduling site visits; explaining the peer review process to the treatment provider; structuring the peer review/organizing the day; using the peer review forms and information gathering tools; writing the peer review report; making travel arrangements and completing travel reimbursement forms; and meeting reporting deadlines.

A debriefing session was held, shortly after all site-visits were completed, to allow peer reviewers to share successes and weaknesses of the treatment agencies they visited. A summary report was prepared by the Chair of the Citizen's Advisory Council and presented to the Division Director with recommendations for improvement.

Goal #16: Disclosure of Patient Records

An agreement to ensure that the State has in effect a system to protect patient records from inappropriate disclosure (See 42 U.S.C. §300x-53(b), 45 C.F.R. §96.132(e), and 42 C.F.R. Part 2).

Note: In addressing this narrative the State may want to discuss activities or initiatives related to the provision of: *Confidentiality training/TA; Compliance visits/inspections; Licensure requirements/reviews; Corrective action plans; Peer reviews.*

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

Goal #16 – System to protect patient records
FFY2010 (Intended Use)

All chemical dependency service providers (agencies) certified by DBHR must comply with agency certification requirements that ensure patient confidentiality and protect patient records from inappropriate disclosure.

Certified agencies will continue to be required by law and rule (RCW and WAC) to meet federal and state confidentiality requirements and to actively maintain systems to protect patient records from inappropriate disclosure. Certified treatment agencies are required by WAC 388-805- 140(8)(b), 150(10), and 305(1)(e) to have procedures in place protecting confidentiality of patient records and requiring all clinical and personal information be handled in accordance with state and federal laws. These specific requirements are found in WAC 388-805, *Certification Requirements for Chemical Dependency Service Providers* located at: http://apps.leg.wa.gov/WAC/default.aspx?cite=388-805.

All DBHR-certified chemical dependency treatment agencies will implement policies and procedures per federal and state laws and rules protecting patient confidentiality and protecting patient records from inappropriate disclosure. As part of the initial DBHR-certification process, DBHR staff members will review and verify each new agency's policies, procedures, and forms implementing confidentiality requirements.

DBHR, through WAC 388-805, will require all certified treatment agencies to implement policies and procedures to protect patient records from inappropriate disclosure. Through WAC 388- 805, DBHR specifically requires an agency's governing board [WAC 388-805-140(8)(b)] and agency administrator [WAC 388-805-150(10)] to implement policies and procedures protecting patient confidentiality. DBHR will continue to require all certified agencies to adopt patient rights policies that include the protection of clinical and personal information [WAC 388-805-305(1)(e). The WAC Implementation Guide (WIG) specifies penalties for breach of patient confidentiality. The WIG is located at: http://www.dshs.wa.gov/DASA/services/certification/Main/WACs-WIG.shtml.

During FFY 2011-2013, the DBHR Certification staff will focus on compliance with confidentiality laws and provide technical assistance as needed on confidentiality issue. These activities will occur as part of on-site surveys of certified agencies. DBHR Certification staff members expect to complete 180 individual agency on-site surveys per FFY. The average number of state-certified programs should be about 590 during this period.

During each on-site survey, DBHR Certification Specialists will use extensive checklists while conducting patient record reviews to assess compliance with the WAC 388-805 requirements listed above. The patient records checklists are authorized by WAC 388-805-325(5) and 325(16) so Certification Specialists check every patient record in our random selection of records to ensure that patients sign forms acknowledging that they were informed about the state and federal confidentiality rules. They will also check every patient record selected for properly completed release of information forms. DBHR's patient records checklists will include all nine required elements for properly completed release of information forms (42 CFR Part 2) and also include required elements from 45 CFR Parts 160 and 164. Federal CFRs are located at: http://www.gpoaccess.gov/cfr/index.html.

After every on-site survey, Certification Specialists will complete an on-site survey report that lists each deficiency, requests corrective action plans if necessary, and conduct follow up on-site surveys to ensure implementation of corrective action.

The DBHR Certification Section Complaint Manager will record complaints from stakeholders about potential breaches of patient confidentiality by certified agency staff members. The Complaint Manager will focus on confidentiality and provide technical assistance about confidentiality and privacy issues while handling complaint allegations.

The DBHR Certification Section expects interagency collaborative treatment efforts will continue with additional requests for technical assistance about confidentiality requirements for multiple party releases of information forms and cross-agency sharing of patient information. During FFY 2011-2013, DBHR will revise and implement consent forms to enhance communication between:

- Patients
- Chemical Dependency Professionals and DBHR-certified agencies
- The Department of Social and Health Services, DBHR
- The Department of Social and Health Services, Medicaid Purchasing Authority
- The Department of Social and Health Services, Client Registry
- ADATSA Assessment Centers

DBHR staff members will also participate in division meetings and discussions about electronic public records requests, electronic client databases, and electronic health care systems during FFY 2011-2013 as part of health care reform.

Goal #16 – System to protect patient records
FFY 2008 (Compliance)

All DBHR treatment contractors are required by contract and rule (RCW and WAC) to meet federal and state confidentiality requirements and to actively maintain systems to protect patient records from inappropriate disclosure.

DBHR, through WAC 388-805 (see http://apps.leg.wa.gov/WAC/default.aspx?cite=388-805) requires d all certified treatment agencies to implement polices and procedures to protect patient records from inappropriate disclosure. Through WAC 388-805, DBHR specifically required an agency's governing board [WAC 388-805-140(8)(b)] and agency administrator [WAC 388-805-150(10)] to implement policies and procedures protecting patient confidentiality. DBHR further required all certified agencies to adopt patient rights that include the protection of clinical and personal information [WAC 388-805-305(1)(e). The WAC Implementation Guide (WIG) specifies penalties for breach of patient confidentiality. The WIG is located at: http://www.dshs.wa.gov/DASA/services/certification/Main/WACs-WIG.shtml.

During FFY 2008, the DBHR Certification staff focused on compliance with confidentiality laws and provided technical assistance as needed on confidentiality issues while conducting on-site surveys of certified agencies. The total number of state-certified programs on September 30, 2008, was 577. By September 30, 2008, the DBHR Certification staff had completed about 175 (137 routine and 38 corrective action plan implementation) on-site and technical assistance surveys.

During each on-site survey, DBHR Certification Specialists used extensive checklists while conducting patient record reviews to assess compliance with the WAC 388-805 requirements listed above. The patient records checklists are authorized by WAC 388-805-325(5) and 325(16). Certification Specialists checked random selection of patient records to ensure that patients signed forms acknowledging that they were informed of state and federal confidentiality rules and that every patient record had properly completed release of information forms. DBHR's patient records checklists included all nine required elements for properly completed release of information forms (42 CFR Part 2) and also included required elements from 45 CFR Parts 160 and 164.

After every on-site survey, Certification Specialists completed an on-site survey report that listed each deficiency, requested corrective action plans from certified agencies, and conducted follow-up on-site surveys to ensure implementation of corrective action.

In addition, the DBHR Certification Section Complaint Manager received occasional complaints from a variety of stakeholders about potential breaches of patient confidentiality by certified agency staff members. The Complaint Manager continued to focus on confidentiality and provided technical assistance about confidentiality and privacy issues while handling complaint allegations.

The DBHR Certification Section participated in interagency collaborative efforts and provided technical assistance about confidentiality requirements for multiple party release of information forms and cross-agency sharing of patient information.

As a result of discussions during the FY 2005 Core Technical Review and cross-agency work between Department of Social and Health Services (DSHS) and partner agencies, DBHR asked CSAT to provide additional confidentiality technical assistance training for DBHR, DSHS, and other DBHR stakeholders. Consequently, CSAT conducted training entitled *CSAT Confidentiality and Ethics Training* for a variety of DBHR staff members, stakeholders, and other state agency employees.

Training during the remainder of calendar year 2007/08 included revisions to Washington Administrative Code (WAC) 388-805. The DBHR Certification Section continued to provide technical assistance to other Washington State agencies, mental health systems, the courts, and other health care providers regarding release forms that are compliant with 42 CFR, Part 2, and HIPPA, 45 CFR, Parts 160 and 164. DBHR maintained a contract with the Legal Action Center (LAC) in which DBHR certified agencies could seek advice from LAC about confidentiality and privacy issues. DBHR received a quarterly report from LAC about the number and types of consultations it provided to DBHR certified agencies. About four DBHR-certified treatment agencies asked for and received technical assistance from LAC per quarter in FFY 2008.

Goal #16 – System to protect patient records
FFY2010 (Progress)

Activity 16.1:

All DBHR-certified agencies are required by rule (RCW and WAC) to meet federal and state confidentiality requirements and to actively maintain systems to protect patient records from inappropriate disclosure. DBHR-certified treatment agencies are required by WAC 388-805- 140(8)(b), 150(10), and 305(1)(e) to have procedures in place protecting confidentiality of patient records and requiring all clinical and personal information be handled in accordance with state and federal laws. These specific requirements are found in WAC 388-805, *Certification Requirements for Chemical Dependency Service Providers* located at:
http://apps.leg.wa.gov/WAC/default.aspx?cite=388-805.

All DBHR-certified chemical dependency treatment agencies have implemented policies and procedures, per federal and state laws and rules that protect patient confidentiality and protect patient records from inappropriate disclosure. As part of the initial DBHR-certification process, DBHR staff review and verify that each new agency's policies, procedures, and forms implement confidentiality requirements.

DBHR, through WAC 388-805 require all certified treatment agencies to implement policies and procedures to protect patient records from inappropriate disclosure. Through WAC 388- 805, DBHR specifically requires an agency's governing board [WAC 388-805-140(8)(b)] and agency administrator [WAC 388-805-150(10)] to implement policies and procedures to protect patient confidentiality. DBHR requires all certified agencies to adopt patient rights policies that include the protection of clinical and personal information [WAC 388-805-305(1)(e). The WAC Implementation Guide (WIG) specifies penalties for breach of patient confidentiality. The WIG is located at:
http://www.dshs.wa.gov/DBHR/services/certification/main/WACs-WIG.shtml.

During FFY 2010, the DBHR Certification staff continue to focus on compliance with confidentiality laws and provide technical assistance as needed on confidentiality issues while conducting on-site surveys of certified agencies. DBHR Certification staff have completed 80 on-site surveys from October 1, 2009, through May 31, 2010. We anticipate completing another 70 on-site surveys, for a total of about 150 on-site surveys, by the close of FFY 2010. The average number of state-certified programs should be about 590 during this period.

During each on-site survey, DBHR Certification Specialists use extensive checklists while conducting patient record reviews to assess compliance with the WAC 388-805 requirements listed above. The patient records checklists are authorized by WAC 388-805-325(5) and 325(16) so Certification Specialists check every patient record in our random selection of records to ensure that patients sign forms acknowledging that the were informed about state and federal confidentiality rules and to check every patient record selected for properly completed release of information forms. DBHR's patient records checklists include all nine required elements for properly completed release of information forms (42 CFR Part 2) and also include required elements from 45 CFR Parts 160 and 164.

After every on-site survey, Certification Specialists will complete an on-site survey report that lists each deficiency, will request corrective action plans if needed, and will conduct follow up on-site surveys to ensure implementation of corrective action.

The DBHR Certification Section Complaint Manager recordss complaints from stakeholders about potential breaches of patient confidentiality by certified agency staff members. The Complaint Manager

focuses on confidentiality and provides technical assistance about confidentiality and privacy issues while handling complaint allegations.

The DBHR Certification Section expects further interagency collaborative efforts to continue with additional requests for technical assistance about confidentiality requirements for multiple party release of information forms and cross-agency sharing of patient information. During the remainder of FFY 2010, DBHR will revise and implement consent forms to enhance communication between:

- Patients
- Chemical Dependency Professionals and DBHR-certified agencies
- The Department of Social and Health Services, DBHR
- The Department of Social and Health Services, Medicaid Purchasing Authority
- The Department of Social and Health Services, Client Registry
- DBHR ADATSA Assessment Centers

Goal #17: Charitable Choice

An agreement to ensure that the State has in effect a system to comply with services provided by non-governmental organizations (See 42 U.S.C. §300x-65 and 42 C.F.R. part 54 (See 42 C.F.R. §54.8(b) and §54.8(c)(4), Charitable Choice Provisions; Final Rule (68 FR 189, pp. 56430-56449, September 30, 2003).

Note: In addressing this narrative *please specify if this provision was not applicable because State did not fund religious providers. If* the State did fund religious providers, it may want to discuss activities or initiatives related to the provision of: *Training/TA on regulations; Regulation reviews; Referral system/process; Task force/work groups; Provider surveys; Request for proposals; Administered vouchers to ensure patient choice.*

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

Goal #17 – Charitable Choice
FFY 2011 - 2013 (Intended Use)

DBHR-certified and contracted treatment agencies are required by WAC 388-805-140(8)(b), WAC 388-805- 305(1)(i), (2)(a-c), (6), and (7), and WAC 388-805-310(4)(d)(ii) to have procedures in place implementing Charitable Choice provisions. These specific requirements are found in WAC 388- 805, *Certification Requirements for Chemical Dependency Service Providers* located at: http://apps.leg.wa.gov/WAC/default.aspx?cite=388-805.

Provisions to be included in FY2011-2013 county/tribal contracts include:

- Ensure treatment providers give notice to all potential and actual program beneficiaries (services recipients) of their right to alternative services.
- Religious organizations that are providers will refer program beneficiaries to alternative services.
- Providers will either fund and/or provide alternative services.

As part of the initial DBHR-certification process, DBHR staff members will review and verify each new agency's policies, procedures, and forms implementing Charitable Choice provisions. DBHR will review every new agency's patient rights policies to ensure they contain WAC 388-805 sections 305(1)(i), 305(2)(a-c), 305(6), and 305(7).

During FFY 2011 - 2013, the DBHR Certification staff will continue to schedule and monitor implementation of Charitable Choice requirements while conducting on-site surveys of certified agencies throughout the state. DBHR Certification staff members expect to complete individual agency on-site surveys on all publicly-funded providers during FFY 2011 - 2013.

During each on-site survey, DBHR Certification Specialists will use extensive checklists while conducting patient record reviews to assess compliance with the WAC 388-805 requirements listed above. DBHR's patient records checklists include specific reference to WAC 388-805-310(4)(d)(ii): documenting of treatment options, patient choice, and patient rights.

After each on-site survey, Certification Specialists will complete an on-site survey report that lists deficiencies, request corrective action plans if needed, and conduct follow-up on-site surveys to ensure implementation of corrective action.

The DBHR Certification Section Complaint Manager will receive and categorize complaints from a variety of stakeholders that allege noncompliance and complaints about Charitable Choice provisions.

All service recipients, during 2011 – 2013, that request an alternate provider will be referred to another DBHR-certified, public-funded treatment agency.

Activity 17-2
DBHR will identify and track Charitable Choice providers and requests from program beneficiaries for alternative services for both treatment and prevention services at the state level.

The term "alternative services" means services determined by the State to be accessible and comparable and provided within a reasonable period of time from another substance abuse provider ("alternative provider") to which the program beneficiary ("services recipient") has no religious objection.

DBHR Certification Section staff, regional administrators, and contract managers conduct contract and facility monitoring at scheduled intervals consistent with contract monitoring expectations and certification procedures at least once every three years.

The Treatment and Report Generation Evaluation Tool (TARGET) data system will collect Charitable Choice discharge data from DBHR certified and contracted treatment agencies and that data is reviewed by DBHR staff during on-site contract monitoring surveys. A comparable system for collecting prevention data will be developed to collect Charitable Choice conflicts in prevention activities. Comparable system is a system that has comparable attributes related to the goals.

During FFY2011 - 2013, DBHR will track the total number of clients discharged from public-funded treatment services and participants in prevention activities. DBHR will compare those to the total number of each grouping that were related to Charitable Choice issues and in need of a referral to alternative services. A Charitable Choice termination of service will be defined to mean a client/participant who chooses to pursue alternative options due to religious or moral convictions.

Activity 17-3
A system has been developed to register all charitable choice treatment and prevention providers in each sub-state planning area which will be utilized during FFYs 2011 – 2013.

The TARGET data collection tool will collect Charitable Choice discharge data for recipients of treatment services from DBHR certified and contracted treatment agencies and that data will be reviewed by DBHR staff during on-site contract monitoring surveys. For prevention service providers, a similar data collection system will collect Charitable Choice data that will be utilized by DBHR contract managers to assure compliance.

Washington state counties will be required by contract to track the number of service recipients during FFY 2011 – 2013 that request an alternate provider to ensure those recipients are referred to another public-funded treatment agency.

DBHR will track the total number of clients discharged from public-funded services and compare those to the total number of clients discharged that are related to Charitable Choice. A Charitable Choice termination of service will be defined to mean a client/participant who chooses to pursue alternative options due to religious or moral convictions.

Goal #17 Charitable Choice
FY 2008 (Compliance)

Activity 17-1
In the FFY 2008, all DBHR-certified agencies that received SAPT funds and/or state funds were required by rule (RCW and WAC) to meet federal Charitable Choice requirements. DBHR-certified and contracted treatment agencies are required by WAC 388-805-140(8)(b), WAC 388-805-305(1)(i), (2)(a-c), (6), and (7), and WAC 388-805-310(4)(d)(ii) to have procedures in place implementing Charitable Choice provisions. These specific requirements are found in WAC 388-805, *Certification Requirements for Chemical Dependency Service Providers* located at: http://apps.leg.wa.gov/WAC/default.aspx?cite=388-805.

In addition, DBHR contracts during FFY2008 (and beyond) with counties and Indian Nations contained Charitable Choice provisions.

Contracts included language ensuring providers (1) provide notice of their right to alternative services to all potential and actual program beneficiaries (services recipients); (2) ensure that religious organizations that are providers refer program beneficiaries to alternative services; and, (3) fund and/or provide alternative services. The term "alternative services" means services determined by the State to be accessible and comparable and provided within a reasonable period of time from another substance abuse provider ("alternative provider") to which the program beneficiary ("services recipient") has no religious objection.

As part of the initial DBHR-certification process, DBHR staff members reviewed and verified each new agency's policies, procedures, and forms implementing Charitable Choice.

All DBHR contract managers reviewed, as part of their site visit protocols, placement and discharge data from providers throughout the six regions of the state. No contractors were found out of compliance. Systematic trends on charitable choice related discharges were not noted. *In FFY 2008, 194 (0.4%) of 47,725 discharges were associated with charitable choice requests*. During that same time period, there is no record of a concern or complaint from a client receiving services under block grant funding.

Goal #17 - Charitable Choice
FFY 2010 (Progress)

Activity 17-1

All certified chemical dependency service providers (agencies) must comply WAC 388-805-140(8)(b), WAC 388-805-305(1)(i), (2)(a-c), (6), and (7), and WAC 388-805-310(4)(d)(ii) to have procedures in place implementing Charitable Choice provisions. Provisions include:

- Treatment providers must give notice to all potential and actual program beneficiaries (services recipients) of their right to alternative services.
- Religious organizations that are providers must refer program beneficiaries to alternative services, if requested.
- Providers must either fund and/or provide alternative services.

These specific requirements are found in WAC 388-805, *Certification Requirements for Chemical Dependency Service Providers* located at: http://apps.leg.wa.gov/WAC/default.aspx?cite=388-805.

As part of the initial DBHR-certification process, DBHR staff members review and verify each new agency's policies, procedures, and forms implementing Charitable Choice provisions.

During FFY 2010, the DBHR Certification staff monitored the implementation of Charitable Choice requirements while conducting on-site surveys of certified agencies.

DBHR Certification Specialists use extensive checklists while conducting patient record reviews to assess compliance with the WAC 388-805 requirements listed above. DBHR's patient records checklists include specific reference to WAC 388-805-310(4)(d)(ii): documenting of treatment options, patient choice, and patient rights.

After each on-site survey, Certification Specialists complete an on-site survey report that lists deficiencies, request corrective action plans if needed, and conduct follow-up on-site surveys to ensure implementation of corrective action.

The DBHR Certification Section Complaint Manager receives complaints from a variety of stakeholders that allege noncompliance with Charitable Choice provisions.

All chemical dependency treatment agencies must comply with agency certification requirements that ensure treatment providers give notice to patients of Charitable Choice provisions. DBHR identifies and tracks Charitable Choice providers and requests from program beneficiaries for alternative services.

All service recipients during 2010 that request an alternate provider are referred to another DBHR-certified, public-funded treatment agency.

The term "alternative services" means services determined by the State to be accessible and comparable and provided within a reasonable period of time from another substance abuse provider ("alternative provider") to which the program beneficiary ("services recipient") has no religious objection.

DBHR Certification Section staff members, regional administrators, and contract managers conduct contract and facility monitoring at scheduled intervals consistent with contract monitoring expectations and certification procedures at least once every three years.

DBHR tracks the total number of clients discharged from public-funded treatment services during FFY2010 and compares to the total number of clients discharged that were related to Charitable Choice

issues and in need of a referral to alternative services. A Charitable Choice discharge is defined in the TARGET data dictionary to mean a client chose to enter treatment at another treatment facility due to religious or moral convictions. It is anticipated that the final number for FFY2010 will be similar to those in FFY 2009. *A preliminary estimate, based on available data, reports that 138 clients have been discharged from services due to a charitable choice discharge. That is 0.3% of a total client count of approximately 60,518.*

Charitable Choice (formerly Attachment I)

Under Charitable Choice, States, local governments, and religious organizations, each as SAMHSA grant recipients, must: (1) ensure that religious organizations that are providers provide notice of their right to alternative services to all potential and actual program beneficiaries (services recipients); (2) ensure that religious organizations that are providers refer program beneficiaries to alternative services; and (3) fund and/or provide alternative services. The term "alternative services" means services determined by the State to be accessible and comparable and provided within a reasonable period of time from another substance abuse provider ("alternative provider") to which the program beneficiary ("services recipient") has no religious objection.

The purpose of Charitable Choice is to document how your State is complying with these provisions.

For the fiscal year prior (FY 2010) to the fiscal year for which the State is applying for funds check the appropriate box(es) that describe the State's procedures and activities undertaken to comply with the provisions.

Notice to Program Beneficiaries -Check all that Apply

- ☑ Used model notice provided in final regulations
- ☐ Used notice developed by State (Please attach a copy in Appendix A)
- ☑ State has disseminated notice to religious organizations that are providers
- ☑ State requires these religious organizations to give notice to all potential beneficiaries

Referrals to Alternative Services -Check all that Apply

- ☐ State has developed specific referral system for this requirement
- ☑ State has incorporated this requirement into existing referral system(s)
- ☑ SAMHSA's Treatment Facility Locator is used to help identify providers
- ☑ Other networks and information systems are used to help identify providers
- ☑ State maintains record of referrals made by religious organizations that are providers
- ☑ 138 Enter total number of referrals necessitated by religious objection to other substance abuse providers ("alternative providers"), as defined above, made in previous fiscal year. Provide total only; no information on specific referrals required.

Brief description (one paragraph) of any training for local governments and faith-based and community organizations on these requirements.

If your State plans to apply for any of the following waivers, check the appropriate box and submit the request for a waiver at the earliest possible date.

- ☐ To expend not less than an amount equal to the amount expended by the State for FY 1994 to establish new programs or expand the capacity of existing programs to make available treatment services designed for pregnant women and women with dependent children (See 42 U.S.C. 300x-22(b)(2) and 45 C.F.R. 96.124(d)).
- ☐ Rural area early intervention services HIV requirements (See 42 U.S.C. 300x-24(b)(5)(B) and 45 C.F.R. 96.128(d))
- ☐ Improvement of process for appropriate referrals for treatment, continuing education, or coordination of various activities and services (See 42 U.S.C. 300x-28(d) and 45 C.F.R. 96.132(d))
- ☑ Statewide maintenance of effort (MOE) expenditure levels (See 42 U.S.C. 300x-30(c) and 45 C.F.R. 96.134(b))
- ☐ Construction/rehabilitation (See 42 U.S.C. 300x-31(c) and 45 C.F.R. 96.135(d))

If your State proposes to request a waiver at this time for one or more of the above provisions, include the waiver request as an attachment to the application, if possible. The Interim Final Rule, 45 C.F.R. 96.124(d), 96.128(d), 96.132(d), 96.134(b), and 96.135(d), contains information regarding the criteria for each waiver, respectively. A formal waiver request must be submitted to SAMHSA at some point in time if not included as an attachment to the application.

Waivers

Waivers

If the State proposes to request a waiver at this time for one or more of the provisions, include the waiver request as an attachment to the application, if possible. The Interim Final Rule, 45 C.F.R. §96.124(d), §96.128(d), §96.132(d), §96.134(b), and §96.135(d), contains information regarding the criteria for each waiver, respectively. A formal waiver request must be submitted to the SAMHSA Administrator following the submission of the application if not included as an attachment to the application.

This narrative response not included because it does not exist or has not yet been submitted.

Form 8 (formerly Form 4)

SUBSTANCE ABUSE STATE AGENCY SPENDING REPORT

Dates of State Expenditure Period: From: 7/1/2008 To: 6/30/2009

	Source of Funds					
Activity	**A.SAPT Block Grant FY 2008 Award (Spent)**	**B.Medicaid (Federal, State and Local)**	**C.Other Federal Funds (e.g., Medicare, other public welfare)**	**D.State Funds**	**E.Local Funds (excluding local Medicaid)**	**F.Other**
Substance Abuse Prevention* and Treatment	$ 25,933,330	$ 57,295,127	$ 11,400,407	$ 68,745,526	$ 139,183	$
Primary Prevention	$ 7,181,513		$	$ 1,124,648	$	$
Tuberculosis Services	$ 0	$	$	$	$	$
HIV Early Intervention Services	$ 0	$	$	$	$	$
Administration: Excluding Program/Provider	$ 1,742,797		$	$ 4,005,596	$	$
Column Total	**$34,857,640**	**$57,295,127**	**$11,400,407**	**$73,875,770**	**$139,183**	**$0**

***Prevention other than Primary Prevention**

Form 8ab (formerly Form 4ab)

Form 8a. Primary Prevention Expenditures Checklist

Activity	SAPT Block Grant FY 2008	Other Federal	State Funds	Local Funds	Other
Information Dissemination	$ 143,630	$	$ 22,493	$	$
Education	$ 2,800,790	$	$ 438,613	$	$
Alternatives	$ 1,651,748	$	$ 258,669	$	$
Problem Identification & Referral	$ 2,010,824	$	$ 314,901	$	$
Community Based Process	$ 359,076	$	$ 56,232	$	$
Environmental	$ 215,445	$	$ 33,740	$	$
Other	$	$	$	$	$
Section 1926 - Tobacco	$	$	$	$	$
Column Total	**$7,181,513**	**$0**	**$1,124,648**	**$0**	**$0**

Form 8b. Primary Prevention Expenditures Checklist

Activity	SAPT Block Grant FY 2008	Other Federal	State Funds	Local Funds	Other
Universal Direct	$	$	$	$	$
Universal Indirect	$	$	$	$	$
Selective	$	$	$	$	$
Indicated	$	$	$	$	$
Column Total	**$0**	**$0**	**$0**	**$0**	**$0**

Form 8c (formerly Form 4c)

Resource Development Expenditure Checklist

Did your State fund resource development activities from the FY 2008 SAPT Block Grant?
(•) Yes ( ) No

Expenditures on Resource Development Activities are:
( ) Actual ( ) Estimated

Activity	Column 1 Treatment	Column 2 Prevention	Column 3 Additional Combined	Total
Planning, Coordination and Needs Assessment	$ 0	$ 204,089	$	$ 204,089
Quality Assurance	$ 7,387	$ 18,378	$	$ 25,765
Training (post-employment)	$ 186,189	$ 588,846	$	$ 775,035
Education (pre-employment)	$ 75,472	$ 59,203	$	$ 134,675
Program Development	$ 1,487,263	$ 138,326	$	$ 1,625,589
Research and Evaluation	$ 366,515	$ 37,805	$	$ 404,320
Information Systems	$ 253,931	$ 25,627	$	$ 279,558
Column Total	**$2,376,757**	**$1,072,274**	**$0**	**$3,449,031**

Form 9 (formerly Form 6)

SUBSTANCE ABUSE ENTITY INVENTORY

				FISCAL YEAR 2008			
1. Entity Number	2. I-SATS ID [X] if no I-SATS ID	3. Area Served	4. State Funds (Spent during State expenditure period)	5. SAPT Block Grant Funds for Substance Abuse Prevention and Treatment Services(other than primary prevention)	5a. SAPT Block Grant Funds for Services for Pregnant Women and Women with Dependent Children	6. SAPT Block Grant Funds for Primary Prevention	7. SAPT Block Grant Funds for Early Intervention Services for HIV (if applicable)
3	WA750360	Adams County	$155,242	($11,259)	$0	$26,298	$0
4	WA100327	Kitsap County	$444,351	$119,146	$33,640	$0	$0
5	WA903183	King County	$23,865	$161,541	$0	$206,930	$0
6	WA102075	Snohomish County	$3,600,481	$1,389,260	$0	$0	$0
7	X	Spokane County	$0	$0	$0	$13,493	$0
9	X	Asotin County	$36,752	$0	$0	$27,864	
11	X	Statewide (optional)	$0	$5,535	$0	$0	$0
13	WA100538	Franklin County	$112,764	$32,283	$0	$15,904	$0
17	WA100662	King County	$11,780	$0	$0	$0	$0
19	WA100621	Klickitat County	$244,148	$42,519	$0	$0	$0
24	X	Clallam County	$132,579	$1,400	$0	$15,149	$0
25	X	Clark County	$525,262	$19,242	$0	$60,133	$0
26	X	Clark County	$0	$4,034	$0	$0	$0
28	WA902573	Clallam County	$752,131	$658,187	$0	$70,350	$0

31	WA101103	Ferry County	$0	$26,903	$0	$0	$0
33	X	Spokane County	$425,728	$235,147	$0	$0	$0
34	WA904447	Lewis County	$5,941	($4,521)	$0	$58,802	$0
35	X	Cowlitz County	$99,273	$0	$0	$0	$0
36	WA100956	Cowlitz County	$62,129	$65,027	$0	$0	$0
39	WA904629	Spokane County	$1,300,136	$0	$0	$0	$0
41	WA100959	Cowlitz County	$697,630	$111,127	$25,622	$0	$0
42	X	King County	$0	$0	$0	$1,000	$0
45	X	Statewide (optional)	$0	$7,046	$0	$0	$0
47	WA101399	Snohomish County	$0	$2,153	$0	$0	$0
48	WA100457	Spokane County	$233,297	$0	$0	$0	$0
52	WA903555	Garfield County	$178	$0	$0	$0	$0
53	WA100079	King County	$642,438	$295,662	$0	$0	$0
54	WA750931	Grant County	$722,610	$105,491	$22,716	$43,094	$0
55	X	Grays Harbor	$150,200	$3,132	$0	$25,936	$0
56	WA000000	Spokane County	$594,565	$0	$0	$5,000	$0
57	WA100463	Clallam County	$51,854	$163,217	$0	$0	$0
58	X	Statewide (optional)	$0	$8,989	$0	$0	$0
60	X	Island County	$31,093	$0	$0	$32,143	$0
62	WA100970	Clallam County	$4,012	$0	$0	$16,199	$0
63	X	Jefferson County	$0	$0	$0	$31,531	$0
68	X	King County	$2,618,733	$68,957	$0	$244,460	$0
69	X	Statewide (optional)	$0	$0	$0	$164,150	$0
70	WA101396	Kitsap	$468,006	$0	$0	$87,515	$0

70	WA101390	County					
71	X	Kitsap County	$112,107	$23,562	$0	$0	$0
71	WA750394	Kitsap County	$633,489	$818,682	$0	$0	$0
73	WA100863	Spokane County	$693,867	$0	$0	$0	$0
76	WA101021	Lewis County	$98,565	$0	$0	$16,213	$0
77	WA902490	Lincoln County	$114,814	$23,706	$3,503	$31,114	$0
80	X	Clallam County	$14,874	$13,870	$0	$5,227	$0
82	WA100483	Whatcom County	$7,010	$52,024	$0	$7,443	$0
85	WA100566	Clallam County	$318	$30,125	$0	$9,536	$0
86	WA100277	Statewide (optional)	$4,229	$0	$0	$0	$0
86	WA100277	Pierce	$1,035,222	$297,985	$0	$10,890	$0
88	WA104543	King County	$26,795	$48,397	$0	($31,109)	$0
91	WA902839	Thurston County	$3,444	$17,586	$0	$27,945	$0
93	WA904207	Whatcom County	$4,451	$46,910	$0	$0	$0
94	X	Thurston County	$18,091	$0	$0	$0	$0
95	X	Statewide (optional)	$11,000	$89,781	$0	$12,500	$0
96	WA104345	Grays Harbor	$107,584	$215,215	$0	$0	$0
98	X	Statewide (optional)	$990,342	$0	$0	$2,147,136	$0
100	WA750311	Kitsap County	$0	$213,475	$0	$0	$0
101	X	Thurston County	$1,028	$0	$0	$0	$0
102	X	Statewide (optional)	$63,698	$300,404	$0	$0	$0
103	X	Pacific County	$95,473	$0	$0	$32,515	$0
106	X	Statewide (optional)	$100,008	$0	$0	$0	$0
109	WA105516	Pierce	$102,147	$0	$0	$0	$0
110	X	Pierce	$2,256,156	$35,522	$0	$144,970	
111	WA903035	Whatcom	$86,923	$140,273	$119	$0	$0

111	WA903035	County					
111	WA903035	Skagit County	$6,784,341	$0	$0	$0	$0
112	WA100488	Spokane County	$1,637,779	$0	$0	$0	$0
113	WA101002	Kitsap County	$9,003	$45,904	$0	$28,750	$0
115	WA102588	King County	$94,331	$1,672,362	$0	$0	$0
115	WA102588	Pierce	$892,557	$0	$0	$0	$0
116	WA100222	Grays Harbor	$286,534	$47,961	$0	$0	$0
119	WA100996	Clallam County	$4,140	$7,028	$0	$14,613	$0
120	WA904751	Grays Harbor	$5,820	$31,786	$0	$29,268	$0
121	WA750501	King County	$1,816,121	$1,268,145	$158,684	$0	$0
126	WA903266	King County	$96,432	$6,363	$0	$0	$0
127	WA903712	King County	$417,194	$0	$0	$0	$0
129	X	Mason County	$0	$5,000	$0	$0	$0
132	WA101624	Skagit County	$3,953	$0	$0	$40,890	$0
133	X	San Juan County	$26,944	($306)	$0	$20,613	$0
135	WA101710	King County	$3,539	$0	$0	$34,473	$0
137	WA103412	Snohomish County	$118,276	$57,836	$0	$0	$0
140	WA750592	King County	$645,265	$1,629,582	$0	$0	$0
145	WA101069	Pacific County	$113	$2,881	$0	$29,619	$0
147	X	Skagit County	$206,111	$0	$0	$16,265	$0
148	WA750261	Skagit County	$1,846,671	$173,354	$541	$0	$0
149	WA104865	Skamania County	$59,333	$35,138	$28	$12,314	
150	X	Snohomish County	$894,493	$0	$0	$139,403	$0
151	WA101004	King County	$16,050	$5,519		$31,406	
153	WA904645	Spokane	$388,175	$152,139	$0	$0	$0

153	WA904845	County					
154	X	Spokane County	$687,005	$0	$0	$102,675	$0
156	X	Mason County	$0	$0	$0	$30,627	$0
158	WA100459	Thurston Mason Counties	$1,042,441	$389,583	$0	$0	$0
161	WA101029	Skagit County	$61,135	$0	$0	$0	$0
161	WA101029	Snohomish County	$37,155	$185,559	$0	$0	$0
162	WA904835	Yakima County	$951,087	$286,723	$0	$0	$0
163	WA101044	Kitsap County	$8,640	$6,330	$0	$16,342	$0
164	WA902797	Skagit County	$0	$0	$0	$41,075	$0
165	X	Pierce	$0	$15,730	$0	$0	$0
169	X	Thurston Mason Counties	$360,084	$0	$0	$23,618	$0
170	X	Thurston Mason Counties	$0	$0	$0	$78,661	$0
173	WA100843	King County	$1,869,521	$0	$0	$21,123	$0
174	WA100962	Skagit County	$4,164	$572	$0	$21,975	$0
179	X	Walla Walla County	$80,223	$0	$0	$42,036	$0
180	X	Statewide (optional)	$28,248	$0	$0	$0	$0
182	X	Statewide (optional)	$126,044	$1,533,678	$0	$298,898	$0
184	X	Whatcom County	$213,402	$0	$0	$82,224	$0
184	X	San Juan County	$11,368	$0	$0	$0	$0
187	X	Yakima County	$905,387	$75,132	$0	$0	$0
188	WA751095	Yakima County	$1,577,920	$227,921	$148,146	$0	$0
189	X	Yakima County	$0	$3,962	$0	$0	$0
190	X	Yakima County	$24,000	$0	$0	$0	$0

193	X	Statewide (optional)	$6,623	$0	$0	$0	$0
194	X	Statewide (optional)	$12,536	$0	$0	$0	$0
195	X	Statewide (optional)	$93,092	$0	$0	$0	$0
198	X	Statewide (optional)	$67,588	$0	$0	$0	$0
199	X	Statewide (optional)	$14,761	$0	$0	$0	$0
202	WA100521	Benton County	$44,861	$0	$0	$0	$0
203	WA100512	Clallam County	$22,210	$0	$0	$0	$0
204	WA100494	Snohomish County	$898	$58	$0	$0	$0
210	WA104527	Jefferson County	$278,700	$52,874	$0	$0	$0
211	X	Statewide (optional)	$89,824	$27,678	$27,678	$0	$0
220	X	Thurston County	$0	$4,990	$0	$0	$0
226	WA100501	Mason County	$121,596	$0	$0	$0	$0
227	WA301479	Pierce	$142,324	$195,418	$0	$31,290	$0
235	WA100515	Snohomish County	$4,240	$717	$0	$0	$0
241	WA100451	Clark County	$64,169	$0	$0	$0	$0
242	WA750881	Snohomish County	$282,486	$66,102	$66,102	$0	$0
246	WA100954	Pend Orielle County	$4,827	$0	$0	$27,801	$0
252	WA101392	King County	$435,462	$0	$0	$0	$0
253	WA101006	King County	$123,536	$0	$0	$0	$0
254	WA102687	Whatcom County	$81,980	$24,405	$0	$0	$0
256	X	Skagit County	$196,247	$0	$0	$0	$0
257	WA101028	Mason County	$1,915	$30,869	$0	$18,000	$0
259	X	Spokane County	$198,561	$29,285	$0	$0	$0
260	WA904801	Stevens	$63,519	$0	$0	$41,612	$0

260	WA904801	County					
265	WA100436	Thurston Mason Counties	$126,988	$0	$0	$0	$0
265	WA100436	Thurston County	$158	$0	$0	$0	$0
266	WA100433	King County	$405,283	$88,028	$0	$0	$0
271	WA100791	Skagit County	$176,118	$32,830	$507	$0	$0
273	WA903621	King County	$101,413	$87,183	$10,718	$71,876	$0
274	WA903621	Snohomish County	$17,378	$0	$0	$0	$0
275	X	Statewide (optional)	$0	$0	$0	$13,611	$0
278	WA100440	King County	$63,142	$35,024	$0	$0	$0
280	WA101895	Pierce	$330	$0	$0	$0	$0
281	WA301461	Pierce	$56,335	$7,454	$0	$0	$0
281	WA301461	King County	$208,187	$127,683	$0	$0	$0
283	WA100447	Skamania County	$140,235	$0	$0	$0	$0
285	WA100986	Yakima County	$1,160	$796,396	$0	$0	$0
291	WA100461	Pierce	$24,903	$3,733	$0	$30,894	$0
293	WA100412	King County	$102,986	$4,888	$0	$0	$0
294	WA101051	Clallam County	$3,456	$0	$0	$9,188	$0
295	WA901641	King County	$45,813	$31,039	$0	$0	$0
296	WA301370	Kitsap County	$80,144	$0	$0	$0	$0
297	WA103883	Yakima County	$1,530	$0	$0	$0	$0
298	WA903845	Yakima County	$1,674	$0	$0	$0	$0
303	WA100530	Benton Franklin Counties	$27,364	$12,325	$0	$0	$0
303	WA100530	Walla Walla County	$5,535	$0	$0	$0	$0
303	WA100530	Grant County	$326	$0	$0	$0	$0

308	WA101374	King County	$1,448,176	$0	$0	$0	$0
309	WA100376	Pierce	$897,114	$60,091	$0	$0	$0
312	X	Statewide (optional)	$0	$0	$0	$17,500	$0
317	WA100809	King County	$81,691	$65,069	$0	$0	$0
318	WA100811	King County	$632	$0	$0	$0	$0
321	X	Statewide (optional)	$5,483	$0	$0	$0	$0
322	X	Pierce	$47,581	$166,810	$0	$0	$0
324	WA104105	King County	$2,046,942	$186,677	$61,190	$1,875	$0
325	WA000104	Grays Harbor	$29,781	$24,878	$0	$0	$0
326	WA100264	Clallam County	$38,782	$0	$0	$0	$0
328	WA100284	Yakima County	$2,926	$0	$0	$0	$0
329	WA102725	King County	$34,678	$42,609	$0	$29,438	$0
333	WA900445	King County	$31,105	$40,498	$0	$0	$0
334	WA105219	Columbia County	$89,519	$20,342	$120	$28,329	$0
335	X	Snohomish County	$33,600	$0	$0	$0	$0
337	WA750766	Skagit County	$0	$0	$0	$116,110	$0
338	WA103511	Spokane County	$14,518	$36,544	$0	$0	$0
339	WA102869	Grays Harbor	$53,020	$0	$0	$0	$0
340	WA101416	Benton Franklin Counties	$61,535	$16,303	$0	$0	$0
341	WA100207	Kittitas County	$219,824	$73,827	$615	$0	$0
344	WA903290	King County	$30,240	$39,788	$0	$38,334	$0
346	WA900783	Thurston Mason Counties	$442,087	$158,037	$138,013	$0	$0
347	X	Island County	$12,500	$0	$0	$0	$0
		Thurston	$0	$0	$0	$15,500	$0

347	X	Mason Counties					
347	X	Klickitat County	$0	$0	$0	$1,667	$0
347	X	Snohomish County	$0	$0	$0	$12,500	$0
348	WA102703	Yakima County	$102,224	$22,891	$0	$0	$0
349	WA101770	Kitsap County	$248,326	$0	$0	$0	$0
350	X	Pierce	$239	$0	$0	$0	$0
352	WA103420	Snohomish County	$11,455	$0	$0	$0	$0
353	X	Statewide (optional)	$28,234	$0	$0	$0	$0
354	WA103040	King County	$117,954	$0	$0	$0	$0
355	WA101384	Cowlitz County	$384	$0	$0	$0	$0
356	WA105524	Yakima County	$5,828	$0	$0	$0	$0
361	WA100545	King County	$171,499	$32,415	$0	$0	$0
364	WA102489	Lewis County	$125,206	$39,726	$7,105	$0	$0
365	WA100806	Skagit County	$25,049	$0	$0	$0	$0
366	WA101341	King County	$74,367	$14,388	$0	$38,594	$0
367	WA101583	Pierce	$28,779	$9,477	$0	$0	$0
369	X	Spokane County	$6,340	$0	$0	$0	$0
370	WA903316	King County	$37,842	$15,653	$0	$0	$0
372	X	Statewide (optional)	$184,690	$0	$0	$0	$0
375	WA751194	Clark County	$1,641,108	$829,673	$0	$0	$0
376	WA904470	Benton Franklin Counties	$68,290	$25,611	$773	$0	$0
377	X	King County	$0	$0	$0	$25,000	$0
377	X	Snohomish County	$0	$0	$0	$2,051	$0
378	X	Clark County	$3,134	$0	$0	$0	$0

379	WA100434	Spokane County	$856,021	$54,998	$0	$0	$0
381	WA100478	Spokane County	$2,274,333	$970,290	$16,410	$0	$0
382	WA751129	Okanogan County	$314,601	$91,102	$1,917	$10,505	$0
383	WA100949	Clallam County	$105,285	$0	$0	$0	$0
384	WA750956	Whitman County	$187,166	$37,051	$587	$32,419	$0
385	WA101031	Spokane County	$96,920	$0	$0	$0	$0
390	WA900502	King County	$6,046	$8,538	$0	$37,258	$0
392	WA300067	King County	$129,292	$1,028,700	$0	$0	$0
393	WA100522	Walla Walla County	$215,790	$97,450	$0	$0	$0
395	WA100490	Franklin County	$75,979	$33,608	$0	$0	$0
397	WA101507	Franklin County	$259,331	$74,858	$1,219	$0	$0
398	X	Statewide (optional)	$90,000	$0	$0	$588,846	$0
399	WA100846	King County	$9,626	$3,884	$0	$0	$0
400	X	Whatcom County	$9,520	$0	$0	$0	$0
401	X	King County	$8,765	$0	$0	$0	$0
402	WA903563	Kitsap County	$62,403	$68,199	$0	$0	$0
403	WA100524	Whatcom County	$200,299	$75,811	$0	$0	$0
404	X	King County	$24,560	$0	$0	$0	$0
406	WA903779	Spokane County	$257,962	$104,709	$0	$0	$0
408	X	Snohomish County	$19,998	$0	$0	$0	$0
411	WA100660	Kitsap County	$8,271	$0	$0	$0	$0
412	WA100226	Ferry County	$36,428	$7,139	$0	$10,216	$0
413	WA104824	Skagit County	$80,603	$2,931	$0	$0	$0

415	X	Clark County	$490,367	$321,760	$0	$0	$0
416	X	Statewide (optional)	$14,310	$0	$0	$0	$0
417	WA101448	Franklin County	$10,778	$3,813	$0	$19,220	$0
418	X	Statewide (optional)	$24,428	$0	$0	$0	$0
420	WA103842	King County	$1,366,742	$298,897	$0	$0	$0
421	WA101389	Franklin County	$284,797	$36,249	$0	$0	$0
424	WA101568	Franklin County	$47,595	$10,112	$0	$0	$0
425	WA100775	Snohomish County	$42,193	$0	$0	$0	$0
425	WA100775	King County	$504	$2,154	$0	$2,174	$0
426	WA100776	Clark County	$7,390	$0	$0	$0	$0
427	WA100779	Mason County	$188,308	$0	$0	$0	$0
429	X	King County	$0	$3,525	$0	$0	$0
432	X	Statewide (optional)	$3,999	$0	$0	$0	$0
433	WA100367	King County	$558,787	$178,473	$0	$0	$0
434	WA103685	Wahkiakum County	$141,783	$0	$0	$22,092	$0
435	X	Statewide (optional)	$220,898	$0	$0	$0	$0
436	WA100432	Franklin County	$259,991	$36,421	$0	$18,884	$0
442	WA100968	Island County	$91,035	$185,393	$8,895	$0	$0
443	WA101042	San Juan County	$113,047	$1,246	$0	$0	$0
445	WA100657	Spokane County	$9,163	$0	$0	$0	$0
446	WA903787	Yakima County	$634,409	$266,135	$0	$0	$0
447	WA101903	Pierce	$494	$19	$0	$0	$0
449	WA100749	Mason County	$0	$10,676	$0	$0	$0
450	X	Cowlitz County	$2,610	$3,216	$0	$0	$0

450	X	Clallam County	$10,080	$3,000	$0	$0	$0
451	WA902771	Pend Orielle County	$101,171	$39,026	$1,765	$24,943	$0
453	WA101401	Pierce	$41,858	$6,976	$0	$0	$0
454	WA100227	King County	$641,220	$113,543	$0	$0	$0
455	WA100794	Pierce	$153,652	$37,241	$0	$0	$0
456	WA100830	Cowlitz County	$162,906	$91,390	$0	$0	$0
458	WA101627	Snohomish County	$2,111	$0	$0	$0	$0
459	WA100551	King County	$699,675	$1,291,959	$0	$0	$0
460	WA100496	Thurston Mason Counties	$56,249	$0	$0	$0	$0
461	WA100241	Whatcom County	$158,545	$0	$0	$0	$0
462	WA101569	Grays Harbor	$1,252	$0	$0	$0	$0
463	WA100499	Skagit County	$54,804	$9,115	$0	$0	$0
464	WA101183	Pierce	$53,812	$29,102	$0	$0	$0
467	WA902201	Stevens County	$262,091	$42,392	$0	$22,666	$0
469	WA903696	King County	$1,252	$0	$0	$0	$0
470	WA100319	King County	$3,300	$0	$0	$0	$0
472	WA100583	King County	$269	$0	$0	$0	$0
473	WA100838	Snohomish County	$146,879	$3,603	$0	$0	$0
475	WA000105	Lewis County	$32,802	$20,996	$690	$0	$0
476	WA000102	Thurston Mason Counties	$79,754	$32,518	$0	$0	$0
477	WA000101	Thurston County	$1,070	$0	$0	$0	$0
479	WA100283	Yakima County	$70	$0	$0	$0	$0
480	WA100293	King County	$74,766	$5,490	$0	$0	$0
482	WA100385	Snohomish	$1,338,901	$590,630	$0	$0	$0

482	WA100389	County					
483	WA100392	Snohomish County	$365,036	$283,801	$131,266	$0	$0
485	WA100438	Clark County	$232,642	$0	$0	$35,959	$0
489	WA100715	Lewis County	$84,218	$79,078	$6,364	$0	$0
490	WA100732	Klickitat County	$77	$0	$0	$0	$0
491	WA100856	Thurston Mason Counties	$25,004	$45,780	$0	$0	$0
492	WA100862	Kittitas County	$10,500	$0	$0	$0	$0
493	WA100951	Clark County	$4,401	$0	$0	$0	$0
494	WA100988	Clallam County	$131,668	$0	$0	$0	$0
495	WA101035	Whatcom County	$88,880	$0	$0	$0	$0
496	WA101275	King County	$14,865	$10,802	$0	$0	$0
497	WA101397	Pacific County	$143,361	$12,386	$0	$0	$0
498	WA101450	Skagit County	$78,723	$0	$0	$0	$0
499	WA101452	King County	$0	$11,536	$0	$0	$0
500	WA101576	King County	$1,276	$1,672	$0	$0	$0
501	WA101633	Cowlitz County	$1,683	$997	$0	$1,910	$0
502	WA101662	Thurston Mason Counties	$252,421	$0	$0	$0	$0
503	WA101681	King County	$16,034	$18,874	$15,031	$0	$0
504	WA101702	King County	$0	$0	$0	$30,594	$0
505	WA102570	Pierce	$683,105	$142,451	$22,414	$0	$0
506	WA103628	Whatcom County	$230,729	$47,140	$0	$0	$0
507	WA103693	Stevens County	$100,685	$11,760	$150	$17,738	$0
508	WA103792	King County	$23,266	$10,242	$0	$0	$0
509	WA105003	Snohomish	$1,576	$0	$0	$0	$0

509	WA105003	County					
510	WA750154	Clallam County	$237,537	$24,506	$5,109	$0	$0
511	WA900155	Yakima County	$326,330	$149,562	$0	$0	$0
512	WA901344	Garfield County	$27,878	$25,196	$0	$27,298	$0
512	WA901344	Asotin County	$190,620	$75,425	$0	$0	$0
513	WA901377	Clallam County	$0	$9,175	$0	$0	$0
514	WA903761	Spokane County	$65,742	$886,972	$0	$0	$0
515	WA100392	Skagit County	$32,769	$0	$0	$375	$0
516	WA101061	Pierce	$19,041	$0	$0	$0	$0
517	WA101108	King County	$58,245	$0	$0	$0	$0
518	WA101225	Whatcom County	$2,000	$2,552	$0	$0	$0
519	WA101749	Spokane County	$64,076	$0	$0	$0	$0
520	WA101879	Pierce	$0	$110,554	$110,554	$0	$0
521	X	Skagit County	$0	$0	$0	$421	$0
522	X	Thurston County	$26,500	$0	$0	$0	$0
523	X	Whatcom County	$0	$450	$0	$0	$0
524	X	Jefferson County	$0	$2,500	$0	$0	$0
526	X	Lewis County	$0	$0	$0	$36,960	$0
527	X	Statewide (optional)	$0	$0	$0	$2,118	$0
528	X	Statewide (optional)	($1,342,011)	$0	$0	$0	$0
529	X	Spokane County	$0	$0	$0	$21,571	$0
529	X	Clark County	$0	$0	$0	$13,666	$0
530	X	Snohomish County	$26,000	$0	$0	$0	$0
531	X	Pierce	$0	$11,117	$0	$0	$0
532	X	Snohomish County	$0	$441	$0	$0	$0
533	X	Spokane	$0	$0	$0	$5,400	$0

533	X	County					
534	X	Spokane County	$0	$2,513	$0	$0	$0
535	X	Spokane County	$78,921	$83,884	$83,884	$0	$0
536	X	King County	$0	$83	$0	$0	$0
537	X	Whatcom County	$6,303	$0	$0	$0	$0
538	X	Cowlitz County	$1,271	$0	$0	$0	$0
539	X	Island County	$12,021	$0	$0	$9,864	$0
540	X	Cowlitz County	$0	$0	$0	$7,894	$0
541	X	Clallam County	$0	$0	$0	$18,150	$0
542	X	Cowlitz County	$1,206	$0	$0	$0	$0
543	X	Cowlitz County	$0	$0	$0	$6,900	$0
544	X	Pierce	$0	$0	$0	$2,644	$0
545	X	Yakima County	$0	$900	$0	$0	$0
546	X	Snohomish County	$0	$0	$0	$1,806	$0
547	X	Cowlitz County	$0	$0	$0	$25,267	$0
548	X	Snohomish County	$0	$263	$0	$0	$0
549	X	Snohomish County	$0	$2,864	$0	$0	$0
550	X	Snohomish County	$0	$828	$0	$0	$0
551	X	Yakima County	$0	$0	$0	$82,253	$0
552	X	Thurston County	$38,793	$0	$0	$0	$0
553	X	King County	$0	$0	$0	$35,147	$0
554	X	King County	$0	$0	$0	$450	$0
555	X	Klickitat County	$0	$0	$0	$5,488	$0
556	X	Snohomish County	$0	$0	$0	$14,688	$0
557	X	Clark	$0	$0	$0	$2,624	$0

557	X	County					
558	X	Thurston Mason Counties	$0	$0	$0	$6,105	$0
559	X	Statewide (optional)	$0	$0	$0	$10	$0
560	X	Thurston County	$0	$123	$0	$0	$0
561	X	King County	$0	$3,862	$0	$0	$0
562	X	Lewis County	$0	$417	$0	$0	$0
563	X	King County	$0	$0	$0	$40,834	$0
564	X	Snohomish County	$0	$0	$0	$14,482	$0
565	X	Walla Walla County	$27,481	$0	$0	$0	$0
566	X	King County	$0	$0	$0	$32,327	$0
568	X	Cowlitz County	$216	$4,654	$0	$0	$0
569	X	Grays Harbor	$0	$383	$0	$0	$0
570	X	Whatcom County	$0	$327	$0	$0	$0
571	X	Statewide (optional)	$8,000	$0	$0	$0	$0
572	X	Spokane County	$0	$74	$0	$0	$0
573	X	Pierce	$0	$0	$0	$16,565	$0
574	X	Island County	$15,238	$0	$0	$0	$0
575	X	Statewide (optional)	$19,000	$0	$0	$0	$0
576	X	Pierce	$16,160	$0	$0	$0	$0
577	X	Spokane County	$500	$0	$0	$0	$0
578	X	King County	$882,138	$0	$0	$0	$0
579	X	Kittitas County	$0	$0	$0	$31,366	$0
580	X	Klickitat County	$23,408	$405	$0	$17,447	$0
581	X	Snohomish County	$0	$0	$0	$13,631	$0

582	X	Spokane County	$0	$0	$0	$21,848	$0
583	X	King County	$0	$0	$0	$38,296	$0
584	X	Snohomish County	$0	$20	$0	$0	$0
585	X	Cowlitz County	$0	$0	$0	$307	$0
586	X	San Juan County	$0	$0	$0	$6,974	$0
587	X	Clallam County	$3,903	$0	$0	$0	$0
587	X	Snohomish County	$0	$0	$0	$12,428	$0
588	X	Klickitat County	$0	$0	$0	$7,349	$0
589	X	Spokane County	$0	$0	$0	$22,575	$0
590	X	Statewide (optional)	$0	$1,282	$0	$0	$0
591	X	King County	$0	$0	$0	$390	$0
592	X	Pierce	$1,859	$0	$0	$39,075	$0
593	X	Pierce	$0	$0	$0	$73,041	$0
594	X	Skagit County	$0	$0	$0	$637	$0
595	X	King County	$0	$0	$0	$38,534	$0
596	X	Snohomish County	$0	$4,950	$0	$0	$0
597	X	Skagit County	$0	$0	$0	$3,640	$0
598	X	Skagit County	$164,798	$0	$0	$0	$0
599	X	Klickitat County	$0	$0	$0	$924	$0
600	X	Spokane County	$0	$4,125	$0	$0	$0
603	X	San Juan County	$0	$0	$0	$960	$0
604	X	Pierce	$0	$0	$0	$37,785	$0
605	X	Snohomish County	$9,300	$24,800	$0	$0	$0
606	X	Statewide (optional)	$35,890	$0	$0	$0	$0
607	X	Cowlitz County	$0	$0	$0	$1,097	$0

608	X	Cowlitz County	$0	$0	$0	$150	$0
609	X	King County	$0	$40	$0	$0	$0
610	X	Cowlitz County	$0	$0	$0	$418	$0
611	X	Pierce	$0	$2,962	$0	$0	$0
612	X	Spokane County	$0	$0	$0	$11	$0
613	X	King County	$134,479	$66,512	$47,004	$0	$0
614	X	Statewide (optional)	$0	$0	$0	($33,510)	$0
615	X	Franklin County	$0	$291	$0	$0	$0
616	X	Island County	$12,500	$0	$0	$0	$0
617	X	Pierce	$0	$5,968	$14	$0	$0
618	X	Statewide (optional)	$0	$0	$0	$257	$0
619	X	Spokane County	$9,873	$0	$0	$0	$0
620	X	Pierce	$7,916	$0	$0	$0	$0
621	X	King County	$0	$0	$0	$35,094	$0
622	X	Whatcom County	$0	$450	$0	$0	$0
623	X	King County	$7,614	$0	$0	$0	$0
624	X	King County	$0	$5,635	$0	$0	$0
625	X	King County	$8,934	$0	$0	$0	$0
626	X	King County	$13,190	$0	$0	$0	$0
627	X	Clark County	$0	$0	$0	$5,288	$0
628	X	Skagit County	$0	$0	$0	$190	$0
629	X	King County	$0	$0	$0	$7,239	$0
630	X	Skagit County	$0	$0	$0	$13,264	$0
631	X	Snohomish County	$9,200	$0	$0	$0	$0
632	X	Island County	$13,159	$0	$0	$0	$0

633	X	Clark County	$18,000	$0	$0	$0	$0
634	X	Cowlitz County	$569	$0	$0	$0	$0
635	X	Pierce	$5,487	$0	$0	$36,082	$0
636	X	Snohomish County	$0	$26,827	$0	$0	$0
637	X	Pierce	$79,000	$0	$0	$0	$0
638	X	Pierce	$0	$198	$0	$0	$0
639	X	King County	$0	$0	$0	$450	$0
640	X	Pierce	$0	$0	$0	$2,343	$0
641	X	Cowlitz County	$0	$0	$0	$201	$0
642	X	Spokane County	$0	$0	$0	$15,677	$0
643	X	Cowlitz County	$0	$0	$0	$2,054	$0
644	X	Skagit County	$0	$0	$0	$380	$0
645	X	Clark County	$0	$0	$0	$2,000	$0
646	X	Clark County	$40,000	$0	$0	$0	$0
647	X	Thurston County	$188,712	$0	$0	$0	$0
648	X	Snohomish County	$0	$17,750	$17,750	$0	$0
649	X	Snohomish County	$1,000	$2,000	$0	$0	$0
670	X	Klickitat County	$0	$0	$0	$1,120	$0
671	X	Statewide (optional)	($1,895,760)	$0	$0	$0	$0
672	X	Spokane County	$0	$0	$0	$19,200	$0
673	X	Klickitat County	$0	$0	$0	$236	$0
674	X	Pierce	$0	$0	$0	$28,073	$0
675	X	Klickitat County	$0	$0	$0	$634	$0
676	X	Spokane County	$0	$0	$0	$31,126	$0
677	WA100911	Yakima County	$1,704	$0	$0	$0	$0
700	X	Statewide (optional)	$312,687	$34,732	$0	($8,272)	$0

Totals:	**$73,875,770**	**$25,933,332**	**$1,176,843**	**$7,123,109**	**$0**

PROVIDER ADDRESS TABLE

Provider ID	Description	Provider Address
3	Adams County	425 E Main, Suite 600 Othello, WA 99344 509-488-5611
5	Alcohol/Drug Help Line	PO Box 80243 Seattle, WA 98108 206-722-3700
7	American Indian Comm Center	801 E Second Suite 10 Spokane, WA 99202 509-534-7210
9	Asotin County	549 Fifth St, Suite A Clarkston, , WA 99403 509-758-3181
11	Bellevue Comm College	3000 Landerholm Circle SE Main Campus, Room R-130B Bellevue, WA 98007-6484 425-564-2012
24	Clallam County	Department of Health & Human Services PO Box 2129 Port Angeles, WA 98362-0149 360-417-2366
25	Clark Co Council on A/D	PO Box 5000 Vancouver, WA 98666-5000
26	Clark College	1933 Fort Vancouver Way Vancouver, WA 98663-3598 360-992-2171
33	Community Detox Services	312 West 8th Avenue Spokane, WA 99204 509-477-4631
35	Cowlitz County	Human Services Department 207 Fourth Ave N Kelso, WA 98626
42	Duwamish Tribe	4717 West Marginal Way Southwest Seattle, WA 98106 206-431-1582
45	Eastern Washington University	Alcohol/Drug Studies Program 202 Sutton Hall Cheney, WA 98004-2431
55	Grays Harbor County	Social Services Dept PO Box 831 Montesano, WA 98563

		360-532-8665
58	Highline Community College	Center for Extended Learning PO Box 9800 Des Moines, WA 98198-9800 206-878-3710
60	Island County	PO Box 5000 Coupeville, WA 98239-5000
63	Jefferson County	PO Box 536 Port Townsend, WA 98368
68	King County	201 S Jackson St Seattle, WA 98104-3856
69	Kit Solutions Inc.	5700 Corporate Dr Pittsburgh, WA 15237 412-366-7188
71	Kitsap Recovery Center	1338 SE Old Clifton Rd Port Orchard, WA 98366
80	Lower Elwha Tribal Council	2851 Lower Elwha Rd Port Angeles, WA 98363 360-452-4432
94	North Thurston Public Schools	305 College St. NE Lacey, WA 98516 360-412-4400
95	NW Crime & Social Research Inc.	Looking Glass Analytics 215 Legion Way SW Olympia, WA 98501 360-570-7531
98	Office of Superintendent of Public Instruction	PO Box 47200 Olympia, WA 98504 360-725-6000
99	Okanogan County	1007 Koala Drive Omak, WA 98847
101	Olympia School District	1113 Legion Way SE Olympia, WA 98501 360-596-6100
102	Oxford House Inc.	1010 Wayne Ave, Suite 300 Silver Spring, MD 20910
103	Pacific County	PO Box98 South Bend, WA 98586
106	Parent Trust for WA Children	2200 Rainier Avenue South Seattle, WA 98144 206-233-0156
110	Pierce County	615 S 9th St, Suite 100 Tacoma, WA 98405-4673
129	S. Puget Intertribal Planning Agency	3104 SE Old Olympic Highway Shelton, WA 98584
133	San Juan County	350 Court St Friday Harbor, WA 98250
147	Skagit County	309 South Third Street

147	Skagit County	Mt. Vernon, WA 98273
150	Snohomish County	3000 Rockefeller Avenue Everett, WA 98201
151	Snoqualmie Tribe	1308 Boalch Avenue Northwest North Bend, WA 98045 425-831-5425
154	Spokane County	W 1026 Broadway Spokane, WA 99260-0180
156	Squaxin Island Tribe	SE 10 Squaxin Ln Shelton, WA 98584 360-426-1582
165	Tacoma Community College	6501 S 19th Street, Building 19 Tacoma, WA 98466 253-566-5213
169	Thurston County	2000 Lakeridge Dr SW Olympia, WA 98502
170	Together	418 Carpenter RD SE Suite 203 Lacey, WA 98503-7905
179	Walla Walla County	PO Box 1754 Walla Walla, WA 99362
180	Washington Pave	6316 So. 12th St. Tacoma, WA 98465
182	Washington State University	PO Box 641025 Pullman, WA 99164
184	Whatcom County	511 Grand Ave, Suite 103 Bellingham , WA 98264
187	Yakima County	128 North Second Street Yakima, WA 98901
189	Yakima Valley Community College	PO Box 22520 Yakima, WA 98907-2520 509-574-4741
190	Yakima Valley Farm Workers Clinic	P.O. Box 190 Toppenish, WA 98948 509-865-6175
191	Klickitat	PO Box 159 White Salmon, WA 98672
193	Trancare/Translink	225 Ohme Garden Rd Wenatchee, WA 98801 509-667-2727
194	Northwest Regional Council	600 Lakeway Drive Bellingham, WA 98225 360-738-4554
195	Hopelink	PO Box 3577 Redmond, WA 98073-3577 425-869-6000
198	Human Services Council	PO Box 587 Everett, WA 98206-1244
	People for People	302/304 W Lincoln Ave

199	People for People Reg 8	Yakima, WA 98902 509-248-6726
200	Paratransit Services Reg 2	4810 Auto Center Way Bremerton, WA 98312
206	Clinical Supervisors Training	Post Office Box 45330 Olympia, WA 98504 360-725-3700
207	Administrator Training	Post Office Box 45330 Olympia, WA 98504 360-725-3700
208	Prevention Summit	c/o DBHR PO Box 45330 Olympia, WA 98504
211	Brigid Collins House	1231 N Garden St, #200 Bellingham, WA 98225-5162
220	Ide Werner	3113 50th Ave SE Olympia, WA 98501-5307
233	Thurston/Mason County	412 Lilly Rd NE Olympia, WA 98516
237	WA Education Foundation	1605 NW Sammamish Rd #100 Issaquah, WA 98027
238	WA ST Cncl on Problem Gambling	1929 4th Avenue East Olympia, WA 98506 360-352-6133
256	Skagit Co District Court	PO Box 518 Mt. Vernon, WA 98273
259	Spokane Regional Health District	1101 W College Ave Spokane, WA 99201
275	Central Washington University	400 East University Way Ellensburg, WA 98926-7469
277	COD Conference	Division of Alcohol & Substance Abuse PO Box 45330 Olympia, WA 98504 360-725-3700
306	Paratransit Services Reg 5	4810 Auto Center Way, Ste. Z Bremerton, WA 98312 360-377-7176
312	Partnership for a Drug Free America	405 Lexington Ave Suite 1601 New York, NY 10174
321	Spec Mobility Svc Reg 10	2101 NE NE Flanders St Portland, OR 97232
322	St Joseph Hospital	1717 S. J St. Tacoma, WA 98405
335	Drug Abuse Council Snohomish County	DBA: Pacific Treatment Alternatives 1114 Pacific Ave Everett, WA 98201

347	Big Brothers Big Sisters	1802 Black Lake Blvd SW, Suite 102 Olympia, WA 98502
350	Centennial 1 & 2	PO Box 45330 Olympia, WA 98504
353	Child Haven	316 Broadway Seattle, WA 98122 206-624-6477
369	Henry Montgomery	905 W. Riverside, Suite 607 Spokane, WA 99201 509-744-0778
372	Jones Advertising Inc.	603 Stewart Street Seattle, WA 98101 206-691-3124
374	Life Changes Chemical Dependency	313 North Morain Street Kennewick, WA 99336 509-783-3766
377	Marc Bolan	6248 4th Ave NE Seattle, WA 98107
378	Mental Health Northwest	[NO ADDRESS PROVIDED]
398	University of Nevada	1664 N. Virginia St Reno, NV 89557 775-784-4700
400	Uhl	DBA: Verry UHL Associates 1470 Telegraph Road Bellingham, WA 98226 360-676-4999
401	Washington-Harvey	DBA: ECAR Counseling Services PO Box 3294 Renton, WA 98056 425-282-6662
404	Whitmire	533 Redmond Place N.E. Renton, WA 98056 425-227-0447
408	National Organization on Fetal Alcohol Syndrome	900 17th Street, NW, Suite 910 Washington, DC 20006 202-785-4585
415	Community Services Northwest	Po Box 1845 Vancouver, WA 98668-1845
416	Department of Personnel	PO Box 47500 Olympia, WA 98504
418	Enterprise for Progress in the Community	2902 Castlevale Rd. Ste. A Yakima, WA 98902
429	Paul Grekin	4131 Woodlawn Ave N Seattle, WA 98103
432	Rite of Passage	22401 39th Ave SE

432	Journeys	Bothell, WA 98021
435	Evergreen Council on Problem Gambling	1929 4th Avenue East Olympia, WA 98506
450	Educational Service District 114	105 National Avenue North Bremerton, WA 98312
521	Anacortes School Disctrict	2200 M Avenue Anacortes, WA 99221
522	Balanced Perspectives	PO Box 4141 Tumwater, WA 98501
523	Dorothy J Berry	4451 Masterson Rd Blaine, WA 98230
524	Marsha Botzer	PO Box 267 Quilcene, WA 98376
526	Centralia College	526 600 West Locust Centralia, WA 98531-4035
527	CHASE Manhattan Bank	DBA: JPMorgan Chase Co PO Box 4471 Carol Stream, IL 60197-4471
528	Children's Administration	
529	Childrens Home Society	2323 N Discovery Pl Spokane Valley, WA 99216
530	Childrens Hospital	900 Pacific Ave #100 Everett, WA 98201
531	Clover Park Technical College	4500 Steilacoom Blvd SW Tacoma, WA 98499
532	Kevin Cole	8923 236th ST SW, #C Edmonds, WA 98026
533	communities in Schools of Spokane	
534	community College of Spokane	PO Box 6000 Spokane, WA 99217-6000
535	Community Minded Enterprises	25 W Main, Suite 310 Spokane, WA 99201
536	Consolidated Food Mgmt, Inc	7429 SE 27th St Mercer Island, WA 98040
537	Cor Comp	
538	Correction Counseling Inc	
539	Coupeville School District CTI	
540	Cowlitz-Wahkiakum Council of Gov	207 Fourth Ave N Kelso, WA 98626
541	CSAP Prevention Activities	
542	CUBS Tranportation	
543	Daily News	P O Box 189 Longview, WA 98632

544	Darth Rose Pak	
545	Thomas C Davidson	621 South 22nd Ave Yakima, WA 98902
546	Deaconess Childrens Service	PO Box 2629 Everett, WA 98213-0629
547	Dianne Swanson	
548	Virginia K Eburn	11814 59th Ave NE Snohomish, WA 98296
549	Edith thornton	
550	Edmonds Community College	20000 68th Ave W Lynnwood, WA 98036
551	Education Serv Dist 105	33 S 2nd Ave Yakima, WA 98902
552	Educational Serv Dist 113	601 McPhee RD SW Olympia, WA 98502-5080
553	Encompass	
554	Enterprise Rent a Car-Seattle	PO Box 34935 Seattle, WA 98124
555	Educ Serv Dist	250 NE 65th Ave Vancouver, WA 98661
556	Parents, Families & Friends	
557	Evergree School District	PO Box 8910 Vancouver, WA 98668-8910
558	Family Education & Support Service	
559	Federal Express	PO Box 94515 Palatine, Il 60094-4515
560	Frank Avery Feeley	2296 56th Ave SE Tumwater, WA 98512
561	Laura C Ferguson	637 NW 80th St Seattle, WA 98117
562	Meri A ford	PO Box 63 Onalaska, WA 98570
563	girl Scouts of Western WA	PO Box 900961 Seattle, WA 98109
564	Granite Falls School District	
565	Greater Columbia	101 N Edison Kennewick, WA 99336-1958
566	Greater Maple Valley CTR	
567	Paul Martin Grekin	
568	Greyhound Transportation	
569	David A Hagan	PO Box 219 Taholoh, WA 98587

570	Margarent Janice Haynes	2411 Old Lakeway Dr Bellingham, WA 98229
571	Norman G Hoffman-Evince	DBA: Enidence Clinical Assessments 29 Peregrine Pl Waynesville, NC 28786
572	Sheri Hoveskeland	1717 W Northwest Blvd Suite C Spokane, WA 99205
573	Indochinese Cultural Services	PO Box 8382 Tacoma, WA 98418
574	Island County Juvenile Drug Court	PO Box 5000 Coupeville, WA 98239
575	James E Sorenson	5483 S. Chester CT Greenwood Village, CO 80111
576	John Steger	DBA: Tahoma Counseling Associates 20 Tacoma Ave, N #B Tacoma, WA 98403
577	Kaydee Steele	10314 E Desmet Spokane Valley, WA 99206
578	King County Drug Court	
579	Kittitas Co Com Pub Hlth	PO Box 881 Ellensburg, WA 98926
580	Klickitat Co Public Health	
581	Learning Coalition	
582	Liberty Park Child Deb Ctr	1417 E Hartson Spokane, WA 99202-3338
583	Lifelone Aids Alliance	1002 E Seneca St Seattle, WA 98122
584	Tui Lindsey	23325 78th Ave W Edmonds, WA 98026
585	Longview School Dist 122	2715 Lilac St Longview, WA 98632
586	Lopez Island Family Resource Ctr	
587	Lutheran Community Srv NW	
588	Lyle Schools	PO Box 368 Lyle, WA 98635-0009
589	MLK Jr Family Outreach	PO Box 40193 Spokane, WA 99202
590	Matthew Shepard Foundation	1580 Lincoln St Suite 1150 Denver, CO 80203
591	John McCombs	720 3rd Ave Suite 1410 Seattle, WA 98104
592	McDap	

593	Mini Grants (Various Schools)	
594	Mt Vernon School District	124 E Lawrence St Mount Vernon, WA 98273
595	Neighborhood House	905 Spruce St #213 Seattle, WA 98104-2474
596	North American Addiction Trng	PO Box 2100 Everett, WA 98203
597	North Cascades Health Council	
598	North sound Regional Support	117 North First St, Suite 8 Mount Vernon, WA 98273-2858
599	Northside Community Education	
600	NW Consortium of CD Education	E 22829 Clearwater Lane Liberty Lake, WA 99019
603	Orcas Island Prevention Partnership	
604	Orting School District	120 Washington Ave N Orting, WA 98360-8403
605	Pacific Treatment Alternatives	1114 Pacific Ave Everett, WA 98201
606	Paratransit Services	4810 Auto Center Way Suite Z Bremerton, WA 98312
607	Pathways 2020	
608	Patricia Gardner	
609	George M Pesho	PO Box 682 Duvall, WA 98019
610	Toutle River Boys Ranch	
611	Pierce College	9401 Farwest Drive SW Lakewood, WA 98498-1999
612	Lorena T Pope	16603 E Washington Rd Valleyford, WA 99036
613	Public Health Department	
614	Puget Sound ESD	800 Oakesdale Ave SW Renton, WA 98057
615	Andrea K Ray	6208 Woodbine Dr Pasco, WA 99301
616	Readiness To Learn	
617	Sterling Regional Toxicology	2617 East L Street, Suite A Tacoma, WA 98421-2201
618	Robert J Richey	10400 Sage Hill Rd SE Warden, WA 98857
619	Rock Point Prop LLC	820 A St, Suite 300 Tacoma, WA 98402

620	Rubicon US Reit Inc	PO box 36520 Louisville, KY 40233-6520
621	Safefutures Youth Center	6337 35th Ave SW Seattle, Wa 98126-3003
622	Robynne L Sapp	4451 Materson Rd Blaine, Wa 98230
623	SATA Family LTD Partnership	DBA: Cherry Hill Bldg 11225 SE 6th ST Suite 220 Bellevue, WA 98004
624	Seattle Central Comm College	1500 Harbard Avenue Seattle, WA 98122-2400
625	Seattle School Dist 001	PO box 34165 Seattle, WA 98124-1165
626	Seavest Realty Inc	PO Box 95430 Seattle, WA 98145-2430
627	Second Steps	2500 Maine St, Suite 120 Vancouver, WA 98660
628	Sedro-Woolley School Dist	801 trail Rd Sedro Woolley, WA 98284
629	Shoreline School Dist	18560 1st Ave NE Shoreline, WA 98155
630	Skagit Co Youth & Family Svc	PO Box 518 Mount Vernon, WA 98273
631	Smokey Point Prop LLC	DBA: Medallion Hotel 16710 Smokey Pt Blvd, Suite 305 Arlington, WA 98223
632	South Whidbey School Dist	PO box 346 Langley, WA 98260-0346
633	SW Washington Medical Center	PO Box 1588 Vancouver, WA 98668-1588
634	Steve Chapman	
635	Sumner School Dist	1202 Wood Ave Sumner, WA 98390
636	Sunrise Services	PO Box 2569 Everett, WA 98213-0569
637	Thomas Wickizer	284 Lear Street Columbus, OH 43206
638	Donald R Tjossem	8903 Kay Peninsula Hwy N Lakebay, WA 98349
639	Total Experience Gospel Choir	PO box 22776 Seattle, Wa 98122-0776
640	PICS (Various Schools)	
641	Tracy Kiger	
642	Transitions	1002 N Superior Spokane, WA 99202
643	Turning Technologies	
		Dept 5008

644	United General Hospital	Dept 3006 PO Box 34936 Seattle, WA 98124-1936
645	Vancouver Housing Authority	
646	Vancouver School District	PO Box 8937 Vancouver, WA 98668-8937
647	Vine St Invest Conduit	PO Box 430 Arlington, WA 98223
648	Volunteers of America	4918 N Madison St Spokane, WA 99205
649	Michael Wagner	24100 43rd Ave W Mountlake Terrace, WA 98043
670	WA Gorge Action Programs	1250 E Steuben St Bingen, WA 98605
671	WA State Dept of Corrections	PO Box 41107 Olympia, WA 98501-1107
672	West Central Community Center	
673	WESTCAP	
674	White River School Dist	
675	Wishram School Dist	
676	YWCA Spokane	930 N Monroe Spokane, WA 99201
700	DBHR Miscellanous	Division of Behavioral Health and Recovery PO Box 45330 Olympia, WA 98504-5330 360-725-3700

Form 9a (formerly Form 6a)

Prevention Strategy Report

Column A (Risks)	Column B(Strategies)	Column C (Providers)
No Risk Category Assigned [-99]	Clearinghouse/information resources centers [1]	3
	Resources directories [2]	2
	Media campaigns [3]	2
	Brochures [4]	4
	Radio and TV public service announcements [5]	2
	Speaking engagements [6]	7
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	16
	Information lines/Hot lines [8]	2
	[9]	13
	Parenting and family management [11]	47
	Ongoing classroom and/or small group sessions [12]	64
	Peer leader/helper programs [13]	20
	Education programs for youth groups [14]	41
	Drug free dances and parties [21]	17
	Youth/adult leadership activities [22]	44
	Community drop-in centers [23]	8
	Community service activities [24]	16
	Student Assistance Programs [32]	8
	Driving while under the influence/driving while intoxicated education programs [33]	1
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	20
	Systematic planning [42]	13
	Multi-agency coordination and collaboration/coalition [43]	24

	Community team-building [44]	10
	Accessing services and funding [45]	10
	Guidance and technical assistance on monitoring enforcement governing availability and distribution of alcohol, tobacco, and other drug use [52]	3
	[71]	22
Children of Substance Abusers [1]	Parenting and family management [11]	1
	Education programs for youth groups [14]	3
	Youth/adult leadership activities [22]	1
	[27]	1
Pregnant Women/Teens [2]	Parenting and family management [11]	1
Violent and Delinquent Behavior [4]	Ongoing classroom and/or small group sessions [12]	1
Mental Health Problems [5]	Parenting and family management [11]	1
Economically Disadvantaged [6]	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	2
	[9]	1
	Parenting and family management [11]	1
	Ongoing classroom and/or small group sessions [12]	1
	Peer leader/helper programs [13]	1
	Education programs for youth groups [14]	2
	Youth/adult leadership activities [22]	1
	[27]	1
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	2
	Multi-agency coordination and collaboration/coalition [43]	3
	Guidance and technical assistance on monitoring enforcement	

	governing availability and distribution of alcohol, tobacco, and other drug use [52]	1
Physically Disabled [7]	Youth/adult leadership activities [22]	1
	Community team-building [44]	1
Abuse Victims [8]	Youth/adult leadership activities [22]	1
Already Using Substances [9]	Brochures [4]	1
	[9]	1
	Community service activities [24]	2
	Driving while under the influence/driving while intoxicated education programs [33]	1
	Multi-agency coordination and collaboration/coalition [43]	1
Homeless and/or Run away Youth [10]	Ongoing classroom and/or small group sessions [12]	2
	Education programs for youth groups [14]	1
Other: General Population [11]	Clearinghouse/information resources centers [1]	1
	Media campaigns [3]	1
	Brochures [4]	1
	Radio and TV public service announcements [5]	4
	Speaking engagements [6]	4
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	8
	[9]	6
	Parenting and family management [11]	3
	Ongoing classroom and/or small group sessions [12]	6
	Peer leader/helper programs [13]	1
	Education programs for youth groups [14]	4
	Drug free dances and parties [21]	12
	Youth/adult leadership activities [22]	10
	Community drop-in centers [23]	5
	Community service activities [24]	8

	[27]	8
	Driving while under the influence/driving while intoxicated education programs [33]	1
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	4
	Systematic planning [42]	4
	Multi-agency coordination and collaboration/coalition [43]	9
	Community team-building [44]	4
	Accessing services and funding [45]	2
	Guidance and technical assistance on monitoring enforcement governing availability and distribution of alcohol, tobacco, and other drug use [52]	2
Other: Health Professional [12]	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	1
Other: High School Students [13]	Speaking engagements [6]	1
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	1
	[9]	1
	Ongoing classroom and/or small group sessions [12]	10
	Peer leader/helper programs [13]	7
	Education programs for youth groups [14]	3
	Drug free dances and parties [21]	2
	Youth/adult leadership activities [22]	6
	Community drop-in centers [23]	1
	Community service activities [24]	3
	[27]	1
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	2
	Systematic planning [42]	2
	Multi-agency coordination and	2

	collaboration/coalition [43]	2
	Community team-building [44]	1
	Accessing services and funding [45]	1
Other: Middle/Jr. High School [14]	Brochures [4]	1
	Speaking engagements [6]	3
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	2
	[9]	2
	Ongoing classroom and/or small group sessions [12]	36
	Peer leader/helper programs [13]	5
	Education programs for youth groups [14]	12
	Drug free dances and parties [21]	4
	Youth/adult leadership activities [22]	19
	Community drop-in centers [23]	2
	Community service activities [24]	8
	[27]	6
	Student Assistance Programs [32]	1
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	4
	Systematic planning [42]	2
	Multi-agency coordination and collaboration/coalition [43]	4
	Community team-building [44]	2
	Accessing services and funding [45]	1
	Guidance and technical assistance on monitoring enforcement governing availability and distribution of alcohol, tobacco, and other drug use [52]	1
Other: Prevention Professional [15]	[9]	2
	Parenting and family management [11]	2
	Ongoing classroom and/or small group sessions [12]	2

	Peer leader/helper programs [13]	2
	Education programs for youth groups [14]	1
	Drug free dances and parties [21]	1
	Youth/adult leadership activities [22]	1
	Community service activities [24]	2
	Systematic planning [42]	2
	Multi-agency coordination and collaboration/coalition [43]	2
	Community team-building [44]	2
	Accessing services and funding [45]	4
Others: Teachers/Administrators/Counselors [16]	Brochures [4]	1
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	1
	[9]	1
	Ongoing classroom and/or small group sessions [12]	5
	Systematic planning [42]	2
	Multi-agency coordination and collaboration/coalition [43]	1
	Community team-building [44]	2
	Accessing services and funding [45]	2
Other: Youth/Minors [17]	Clearinghouse/information resources centers [1]	1
	Brochures [4]	1
	Speaking engagements [6]	1
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	3
	[9]	3
	Parenting and family management [11]	2
	Ongoing classroom and/or small group sessions [12]	22
	Peer leader/helper programs [13]	4
	Education programs for youth groups [14]	12

	Drug free dances and parties [21]	3
	Youth/adult leadership activities [22]	17
	Community drop-in centers [23]	3
	Community service activities [24]	3
	[27]	6
	Student Assistance Programs [32]	3
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	2
	Systematic planning [42]	1
	Multi-agency coordination and collaboration/coalition [43]	2
	Community team-building [44]	1
	Accessing services and funding [45]	1
	Guidance and technical assistance on monitoring enforcement governing availability and distribution of alcohol, tobacco, and other drug use [52]	1
Other: Preschool Students [18]	Ongoing classroom and/or small group sessions [12]	3
	Peer leader/helper programs [13]	1
	Education programs for youth groups [14]	1
	Community drop-in centers [23]	1
	Community service activities [24]	1
	[27]	1
Other: Religious Groups [19]	Speaking engagements [6]	1
	Ongoing classroom and/or small group sessions [12]	1
	Peer leader/helper programs [13]	1
Other: Gays/Lesbians [20]	Education programs for youth groups [14]	1
	Youth/adult leadership activities [22]	1
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	1
	Systematic planning [42]	1

	Multi-agency coordination and collaboration/coalition [43]	1
Other: Parents/Families [21]	Speaking engagements [6]	1
	[9]	3
	Parenting and family management [11]	44
	Ongoing classroom and/or small group sessions [12]	6
	Peer leader/helper programs [13]	3
	Education programs for youth groups [14]	2
	Drug free dances and parties [21]	4
	Youth/adult leadership activities [22]	5
	Community drop-in centers [23]	1
	Community service activities [24]	5
	[27]	7
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	2
	Systematic planning [42]	2
	Multi-agency coordination and collaboration/coalition [43]	3
	Community team-building [44]	1
	Guidance and technical assistance on monitoring enforcement governing availability and distribution of alcohol, tobacco, and other drug use [52]	1
Other: Elderly [22]	Drug free dances and parties [21]	1
	Youth/adult leadership activities [22]	1
	Community drop-in centers [23]	1
	[27]	2
	Systematic planning [42]	1
	Multi-agency coordination and collaboration/coalition [43]	2
Other: Elected Officials [23]	Speaking engagements [6]	1
Other: Elementary School [24]	[9]	2
	Parenting and family management [11]	1
	Ongoing classroom and/or small	28

	group sessions [12]	28
	Peer leader/helper programs [13]	5
	Education programs for youth groups [14]	15
	Drug free dances and parties [21]	2
	Youth/adult leadership activities [22]	9
	Community drop-in centers [23]	1
	Community service activities [24]	2
	[27]	2
	Student Assistance Programs [32]	3
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	3
	Multi-agency coordination and collaboration/coalition [43]	1
	Community team-building [44]	1
Other: Business and Industry [25]	Information lines/Hot lines [8]	1
	[9]	2
	Systematic planning [42]	1
	Multi-agency coordination and collaboration/coalition [43]	1
	Accessing services and funding [45]	1
	Guidance and technical assistance on monitoring enforcement governing availability and distribution of alcohol, tobacco, and other drug use [52]	1
Other: Civic Groups/Coalitions [26]	Resources directories [2]	1
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	1
	Peer leader/helper programs [13]	1
	Youth/adult leadership activities [22]	1
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	1
	Systematic planning [42]	2
	Multi-agency coordination and	

	Multi agency coordination and collaboration/coalition [43]	2
	Community team-building [44]	4
	Accessing services and funding [45]	3
Other: College Students [27]	Ongoing classroom and/or small group sessions [12]	1

Form 10a (formerly Form 7a)

TREATMENT UTILIZATION MATRIX

Dates of State Expenditure Period: From: 7/1/2008 To: 6/30/2009

	Number of Admissions ≥ Number of Persons		Costs per Person		
Level of Care	**A. Number of Admissions**	**B. Number of Persons**	**C. Mean Cost of Services**	**D. Median Cost of Services**	**E. Standard Deviation of Cost**
Detoxification (24-Hour Care)					
Hospital Inpatient			$	$	$
Free-standing Residential	13235	8926	$ 908	$ 536	$ 1209
Rehabilitation / Residential					
Hospital Inpatient			$	$	$
Short-term (up to 30 days)	10274	9229	$ 2311	$ 2435	$ 1489
Long-term (over 30 days)	2771	2545	$ 4823	$ 4174	$ 4302
Ambulatory (Outpatient)					
Outpatient	16733	15401	$ 802	$ 535	$ 827
Intensive Outpatient	14619	13411	$ 1283	$ 1041	$ 1087
Detoxification			$	$	$
Opioid Replacement Therapy (ORT)					
Opioid Replacement Therapy	1987	1844	$ 2135	$ 1984	$ 1338

SOURCE: Treatment and Assessment Report Generation Tool (TARGET), DSHS/DBHR, June 2010.
Admissions to treatment in Table 1 are not unduplicated (i.e., these counts are admission cases, and not individual patients); a patient could have been admitted multiple times within the index period.

For this report where block grant criteria are strictly followed, only admissions associated with an episode that began during the FY are included.
The numbers of persons served in Table 2 were calculated for each modality by taking the first admission (using the patient's Unique Identifier)to unduplicate counts of admissions within a given modality.
Strict adherence to block grant reporting instructions results in an underestimation of clients served because block grant funded services for episodes that began in the prior year but carried over into the current yearare not included on client counts.

"Diagnosis" means that, for admissions and numbers of persons served, all patients were implicitly assigned as "Dependent"; and breakouts by alcohol or substance (i.e., "diagnosis" of alcohol or substance abuse), or alcohol-substance combination (i.e., "dual diagnosis" of alcohol and substance abuse) were determined by the combination of primary, secondary, and tertiary substance of abuse as reported by the patient upon admission.

Excludes private-pay and Department of Corrections patients.
*Outpatient Treatment includes outpatient, MICA outpatient, and group care enhancement treatment modalities.
**Residential treatment includes long-term residential, and recovery house treatment modalities.
Excludes admissions to problem gambling treatment, transitional housing, and assessment services.

Form 10b (formerly Form 7b)

Number of Persons Served (Unduplicated Count) for alcohol and other drug use in state-funded services by age, sex, and race/ethnicity

Age	A. Total	B. White		C. Black or African American		D. Native Hawaiian / Other Pacific Islander		E. Asian		F. American Indian / Alaska Native		G. More than one race reported		H. Unknown		I. Not Hispanic or Latino		J. Hispanic or Latino	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
1. 17 and under	5,151	2,010	1,096	283	80	38	22	45	18	180	133	214	135	654	243	708	287	2,551	1,373
2. 18-24	7,056	2,805	1,972	253	128	47	26	52	25	369	264	158	114	626	217	705	242	3,431	2,365
3. 25-44	17,499	7,016	4,982	1,011	494	102	53	183	45	760	656	251	218	1,291	437	1,334	458	8,839	6,108
4. 45-64	8,001	3,764	1,976	757	222	27	6	61	15	346	183	84	46	398	116	391	107	4,788	2,352
5. 65 and over	186	96	39	10	6	1	0	4	2	13	3	1	0	10	1	7	1	120	48
6. Total	37,893	15,691	10,065	2,314	930	215	107	345	105	1,668	1,239	708	513	2,979	1,014	3,145	1,095	19,729	12,246
7. Pregnant Women	637		438		43		6		1		69		27		53		73		528

Did the values reported by your State on Forms 7a and 7b come from a client-based system(s) with unique client identifiers? Yes No

Numbers of Persons Served who were admitted in a period prior to the 12 month reporting period. 16,346

Numbers of Persons Served outside of the levels of care described in Form 10a.

Description of Calculations

Description of Calculations

If revisions or changes are necessary to prior years' description of the following, please provide: a brief narrative describing the amounts and methods used to calculate the following: (a) the base for services to pregnant women and women with dependent children as required by 42 U.S.C. §300x-22(b)(1); and, for 1994 and subsequent fiscal years report the Federal and State expenditures for such services; (b) the base and Maintenance of Effort (MOE) for tuberculosis services as required by 42 U.S.C. §300x-24(d); and, (c) for designated States, the base and MOE for HIV early intervention services as required by 42 U.S.C. §300x-24(d) (See 45 C.F.R. §96.122(f)(5)(ii)(A)(B)(C)).

This narrative response not included because it does not exist or has not yet been submitted.

SSA (MOE TABLE I)

Total Single State Agency (SSA) Expenditures for Substance Abuse (Table I)

PERIOD (A)	EXPENDITURES (B)	B1(2007) + B2(2008) / 2 (C)
SFY 2008 (1)	**$101,569,878**	
SFY 2009 (2)	**$89,671,680**	**$95,620,779**
SFY 2010 (3)	$ 123,045,633	

Are the expenditure amounts reported in Column B "actual" expenditures for the State fiscal years involved?

FY 2008 ○ Yes ◉ No
FY 2009 ○ Yes ◉ No
FY 2010 ○ Yes ◉ No

If estimated expenditures are provided, please indicate when "actual" expenditure data will be submitted to SAMHSA (mm/dd/yyyy):

The MOE for State fiscal year(SFY) 2010 is met if the amount in Box B3 is greater than or equal to the amount in Box C2 assuming the State complied with MOE Requirements in these previous years.

The State may request an exclusion of certain non-recurring expenditures for a singular purpose from the calculation of the MOE, provided it meets CSAT approval based on review of the following information:

Did the State have any non-recurring expenditures for a specific purpose which were not included in the MOE calculation?

◉ Yes ○ No If yes, specify the amount and the State fiscal year: $ 7576045 , 2010(SFY)

Did the State include these funds in previous year MOE calculations?

○ Yes ◉ No

When did the State submit an official request to the SAMHSA Administrator to exclude these funds from the MOE calculations? (Date)

A change in methodology in SFY10 captures 'aggregate State expenditures' with the exclusions of federal demonstration grants.

TB (MOE TABLE II)

Statewide Non-Federal Expenditures for Tuberculosis Services to Substance Abusers in Treatment (Table II)

(BASE TABLE)

Period	Total of All State Funds Spent on TB Services (A)	% of TB Expenditures Spent on Clients who were Substance Abuser in Treatment (B)	Total State Funds Spent on Clients who were Substance Abusers in Treatment A X B (C)	Average of Columns C1 and C2 C1 + C2 -------- 2 (D)
SFY 1991 (1)	$ 183,584	15 %	$ 27,538	$ 27,538
SFY 1992 (2)	$ 183,584	15 %	$ 27,538	

(MAINTENANCE TABLE)

Period	Total of All State Funds Spent on TB Services (A)	% of TB Expenditures Spent on Clients who were Substance Abusers in Treatment (B)	Total State Funds Spent on Clients who were Substance Abusers in Treatment A X B (C)
SFY 2010 (3)	$	%	$

HIV (MOE TABLE III)

Statewide Non-Federal Expenditures for HIV Early Intervention Services to Substance Abusers in Treatment (Table III)

(BASE TABLE)

Period	Total of All State Funds Spent on Early Intervention Services for HIV (A)	Average of Columns A1 and A2 A1 + A2 --- 2 (B)
SFY 1991 (1)	$	$
SFY 1992 (2)	$	

(MAINTENANCE TABLE)

Period	Total of All State Funds Spent on Early Intervention Services for HIV* (A)
SFY 2010 (3)	$

* Provided to substance abusers at the site at which they receive substance abuse treatment

Womens (MOE TABLE IV)

Expenditures for Services to Pregnant Women and Women with Dependent Children (Table IV)

(MAINTENANCE TABLE)

Period	Total Women's Base (A)	Total Expenditures (B)
1994	**$5,186,165**	
2008		**$10,696,046**
2009		**$10,645,544**
2010		$ 9,197,265

Enter the amount the State plans to expend in FY 2011 for services for pregnant women and women with dependent children (amount entered must be not less than amount entered in Table IV Maintenance - Box A {1994}): $ 9,197,265

Form T1

Most recent year for which data are available	From: 1/1/2008 To: 12/31/2008

Aggregates		
Employment\Education Status – Clients employed or student (full-time and part-time) (prior 30 days) at admission vs. discharge	Admission Clients (T_1)	Discharge Clients (T_2)
Number of clients employed or student (full-time and part-time) [numerator]	5471	6852
Total number of clients with non-missing values on employment\student status [denominator]	30418	30391
Percent of clients employed (full-time and part-time)	17.99%	22.55%

State Description of Employment\Education Status Data Collection (Form T1)

STATE CONFORMANCE TO INTERIM STANDARD	**States should detail exactly how this information is collected. Where data and methods vary from interim standard, variance should be described**
DATA SOURCE	**What is the source of data for table T1? (Select all that apply)** ☐ Client Self Report Client self-report confirmed by another source: ☐ Collateral source ☐ Administrative data source ☐ Other: Specify
EPISODE OF CARE	**How is the admission/discharge basis defined for table T1? (Select one)** ○ Admission is on the first date of service, prior to which no service has bee received for 30 days AND discharge is on the last date of service, subsequent to which no service has been received for 30 days ○ Admission is on the first date of service in a Program/Service Delivery Unit and Discharge is on the last date of service in a Program/Service Delivery Unit ○ Other, Specify:
DISCHARGE DATA COLLECTION	**How was discharge data collected for table T1? (Select all that apply)** ☐ Not applicable, data reported on form is collected at time period other than discharge Specify: ○ In-Treatment data ____ days post admission ○ Follow-up data ____ months post admission ○ Other, Specify: ☐ Discharge data is collected for the census of all (or almost all) clients who were admitted to treatment ☐ Discharge data is collected for a sample of all clients who were admitted to treatment ☐ Discharge records are directly collected (or in the case of early dropouts) are created for all (or almost all) clients who were admitted to treatment ☐ Discharge records are not collected for approximately ____ % of clients who were admitted for

	treatment

RECORD LINKING	**Was the admission and discharge data linked for table T1? (Select all that apply)** ☐ Yes, all clients at admission were linked with discharge data using an Unique Client Identifier (UCID) Select type of UCID: ○ Master Client Index or Master Patient Index, centrally assigned ○ Social Security Number (SSN) ○ Unique client ID based on fixed client characteristics (such as date of birth, gender, partial SSN, etc.) ○ Some other Statewide unique ID ○ Provider-entity-specific unique ID ☐ No, State Management Information System does not utilize UCID that allows comparison of admission and discharge data on a client specific basis (data developed on a cohorts basis) or State relied on other data sources for post admission data ☐ No, admission and discharge records were matched using probabilistic record matching

IF DATA IS UNAVAILABLE	**If data is not reported, why is State unable to report? (Select all that apply)** ☐ Information is not collected at admission ☐ Information is not collected at discharge ☐ Information is not collected by the categories requested ☐ State collects information on the indicator area but utilizes a different measure.

DATA PLANS IF DATA IS NOT AVAILABLE	**State must provide time-framed plans for capturing employment\student status data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and estimates of cost.**

Form T2

Most recent year for which data are available	From: 1/1/2008 To: 12/31/2008

Aggregates

Stability of Housing – Clients reporting being in a stable living condition (prior 30 days) at admission vs. discharge	Admission Clients (T_1)	Discharge Clients (T_2)
Number of clients in a stable living situation [numerator]	29020	29681
Total number of clients with non-missing values on living arrangements [denominator]	33738	33742
Percent of clients in stable living situation	86.02%	87.96%

State Description of Stability of Housing (Living Status) Data Collection (Form T2)

STATE CONFORMANCE TO INTERIM STANDARD

States should detail exactly how this information is collected. Where data and methods vary from interim standard, variance should be described

DATA SOURCE

What is the source of data for table T2? (Select all that apply)

- ☐ Client Self Report

Client self-report confirmed by another source:

- ☐ Collateral source
- ☐ Administrative data source

- ☐ Other: Specify

EPISODE OF CARE

How is the admission/discharge basis defined for table T2? (Select one)

- ○ Admission is on the first date of service, prior to which no service has bee received for 30 days AND discharge is on the last date of service, subsequent to which no service has been received for 30 days
- ○ Admission is on the first date of service in a Program/Service Delivery Unit and Discharge is on the last date of service in a Program/Service Delivery Unit
- ○ Other, Specify:

DISCHARGE DATA COLLECTION

How was discharge data collected for table T2? (Select all that apply)

- ☐ Not applicable, data reported on form is collected at time period other than discharge

Specify:

- ○ In-Treatment data ____ days post admission
- ○ Follow-up data ____ months post admission
- ○ Other, Specify:

- ☐ Discharge data is collected for the census of all (or almost all) clients who were admitted to treatment
- ☐ Discharge data is collected for a sample of all clients who were admitted to treatment
- ☐ Discharge records are directly collected (or in the case of early dropouts) are created for all (or almost all) clients who were admitted to treatment
- ☐ Discharge records are not collected for approximately ____ % of clients who were admitted for treatment

RECORD LINKING

Was the admission and discharge data linked for table T2? (Select all that apply)

- ☐ Yes, all clients at admission were linked with discharge data using an Unique Client Identifier (UCID)

	Select type of UCID: ○ Master Client Index or Master Patient Index, centrally assigned ○ Social Security Number (SSN) ○ Unique client ID based on fixed client characteristics (such as date of birth, gender, partial SSN, etc.) ○ Some other Statewide unique ID ○ Provider-entity-specific unique ID ☐ No, State Management Information System does not utilize UCID that allows comparison of admission and discharge data on a client specific basis (data developed on a cohorts basis) or State relied on other data sources for post admission data ☐ No, admission and discharge records were matched using probabilistic record matching

IF DATA IS UNAVAILABLE	**If data is not reported, why is State unable to report? (Select all that apply)** ☐ Information is not collected at admission ☐ Information is not collected at discharge ☐ Information is not collected by the categories requested ☐ State collects information on the indicator area but utilizes a different measure.

DATA PLANS IF DATA IS NOT AVAILABLE	**State must provide time-framed plans for capturing living status data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and estimates of cost.**

Form T3

Most recent year for which data are available	From: 1/1/2008 To: 12/31/2008

Level of Care		
Short-term Residential (SR)		
Clients without arrests (any charge) (prior 30 days) at admission vs. discharge	Admission Clients (T_1)	Discharge Clients (T_2)
Number of Clients without arrests [numerator]	14356	29881
Total number of clients with non-missing values on arrests [denominator]	33742	33742
Percent of clients without arrests	42.55%	88.56%
Long-term Residential (LR)		
Clients without arrests (any charge) (prior 30 days) at admission vs. discharge	Admission Clients (T_1)	Discharge Clients (T_2)
Number of Clients without arrests [numerator]		
Total number of clients with non-missing values on arrests [denominator]		
Percent of clients without arrests		
Intensive Outpatient (IO)		
Clients without arrests (any charge) (prior 30 days) at admission vs. discharge	Admission Clients (T_1)	Discharge Clients (T_2)
Number of Clients without arrests [numerator]		
Total number of clients with non-missing values on arrests [denominator]		
Percent of clients without arrests		
Outpatient (OP)		
Clients without arrests (any charge) (prior 30 days) at admission vs. discharge	Admission Clients (T_1)	Discharge Clients (T_2)
Number of Clients without arrests [numerator]		
Total number of clients with non-missing values on arrests [denominator]		
Percent of clients without arrests		

State Description of Criminal Involvement Data Collection (Form T3)

STATE CONFORMANCE TO INTERIM STANDARD	**States should detail exactly how this information is collected. Where data and methods vary from interim standard, variance should be described**

DATA SOURCE	**What is the source of data for table T3? (Select all that apply)** ☐ Client Self Report Client self-report confirmed by another source: ☐ Collateral source ☐ Administrative data source ☐ Other: Specify
EPISODE OF CARE	**How is the admission/discharge basis defined for table T3? (Select one)** ○ Admission is on the first date of service, prior to which no service has bee received for 30 days AND discharge is on the last date of service, subsequent to which no service has been received for 30 days ○ Admission is on the first date of service in a Program/Service Delivery Unit and Discharge is on the last date of service in a Program/Service Delivery Unit ○ Other, Specify:
DISCHARGE DATA COLLECTION	**How was discharge data collected for table T3? (Select all that apply)** ☐ Not applicable, data reported on form is collected at time period other than discharge Specify: ○ In-Treatment data ____ days post admission ○ Follow-up data ____ months post admission ○ Other, Specify: ☐ Discharge data is collected for the census of all (or almost all) clients who were admitted to treatment ☐ Discharge data is collected for a sample of all clients who were admitted to treatment ☐ Discharge records are directly collected (or in the case of early dropouts) are created for all (or almost all) clients who were admitted to treatment ☐ Discharge records are not collected for approximately ____ % of clients who were admitted for treatment
RECORD LINKING	**Was the admission and discharge data linked for table T3? (Select all that apply)** ☐ Yes, all clients at admission were linked with discharge data using an Unique Client Identifier (UCID) Select type of UCID: ○ Master Client Index or Master Patient Index, centrally assigned ○ Social Security Number (SSN) ○ Unique client ID based on fixed client characteristics (such as date of birth, gender, partial SSN, etc.) ○ Some other Statewide unique ID ○ Provider-entity-specific unique ID ☐ No, State Management Information System does not utilize UCID that allows comparison of admission and discharge data on a client specific basis (data developed on a cohorts basis) or State relied on other data sources for post admission data ☐ No, admission and discharge records were matched using probabilistic record matching
IF DATA IS UNAVAILABLE	**If data is not reported, why is State unable to report? (Select all that apply)** ☐ Information is not collected at admission ☐ Information is not collected at discharge ☐ Information is not collected by the categories requested ☐ State collects information on the indicator area but utilizes a different measure.
DATA PLANS IF DATA IS NOT AVAILABLE	**State must provide time-framed plans for capturing arrest data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and estimates of cost.**

Form T4

Most recent year for which data are available	From: 1/1/2008 To: 12/31/2008

Aggregates

Alcohol Abstinence – Clients with no alcohol use (all clients regardless of primary problem) (use Alcohol Use in last 30 days field) at admission vs. discharge.	Admission Clients (T_1)	Discharge Clients (T_2)
Number of clients abstinent from alcohol [numerator]	12441	20554
Total number of clients with non-missing values on "used any alcohol" variable [denominator]	25169	25274
Percent of clients abstinent from alcohol	49.43%	81.32%

(1) If State does not have a "used any alcohol" variable, calculate instead using frequency of use variables for all primary, secondary, or tertiary problem codes in which the coded problem is Alcohol (e.g. ,TEDS Code 02)

State Description of Alcohol Use Data Collection (Form T4)

STATE CONFORMANCE TO INTERIM STANDARD

States should detail exactly how this information is collected. Where data and methods vary from interim standard, variance should be described

DATA SOURCE

What is the source of data for table T4? (Select all that apply)

- ☐ Client Self Report
- Client self-report confirmed by another source:
  - ☐ urinalysis,blood test or other biological assay
  - ☐ Collateral source
  - ☐ Administrative data source
- ☐ Other: Specify

EPISODE OF CARE

How is the admission/discharge basis defined for table T4? (Select one)

- ○ Admission is on the first date of service, prior to which no service has bee received for 30 days AND discharge is on the last date of service, subsequent to which no service has been received for 30 days
- ○ Admission is on the first date of service in a Program/Service Delivery Unit and Discharge is on the last date of service in a Program/Service Delivery Unit
- ○ Other, Specify:

DISCHARGE DATA COLLECTION

How was discharge data collected for table T4? (Select all that apply)

- ☐ Not applicable, data reported on form is collected at time period other than discharge
  - Specify:
  - ○ In-Treatment data [ ] days post admission
  - ○ Follow-up data [ ] months post admission
  - ○ Other, Specify:
- ☐ Discharge data is collected for the census of all (or almost all) clients who were admitted to treatment
- ☐ Discharge data is collected for a sample of all clients who were admitted to treatment
- ☐ Discharge records are directly collected (or in the case of early dropouts) are created for all (or almost all) clients who were admitted to treatment
- ☐ Discharge records are not collected for approximately [ ] % of clients who were admitted for treatment

RECORD LINKING	**Was the admission and discharge data linked for table T4? (Select all that apply)** ☐ Yes, all clients at admission were linked with discharge data using an Unique Client Identifier (UCID) Select type of UCID: ○ Master Client Index or Master Patient Index, centrally assigned ○ Social Security Number (SSN) ○ Unique client ID based on fixed client characteristics (such as date of birth, gender, partial SSN, etc.) ○ Some other Statewide unique ID ○ Provider-entity-specific unique ID ☐ No, State Management Information System does not utilize UCID that allows comparison of admission and discharge data on a client specific basis (data developed on a cohorts basis) or State relied on other data sources for post admission data ☐ No, admission and discharge records were matched using probabilistic record matching

IF DATA IS UNAVAILABLE	**If data is not reported, why is State unable to report? (Select all that apply)** ☐ Information is not collected at admission ☐ Information is not collected at discharge ☐ Information is not collected by the categories requested ☐ State collects information on the indicator area but utilizes a different measure.

DATA PLANS IF DATA IS NOT AVAILABLE	**State must provide time-framed plans for capturing alcohol abstinence data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and estimates of cost.**

Form T5

Most recent year for which data are available	From: 1/1/2008 To: 12/31/2008

Aggregates

Drug Abstinence – Clients with no drug use (all clients regardless of primary problem) (use Any Drug Use in last 30 days field) at admission vs. discharge.	Admission Clients (T_1)	Discharge Clients (T_2)
Number of Clients abstinent from illegal drugs [numerator]	12939	22118
Total number of clients with non-missing values on “used any drug” variable [denominator]	28314	28401
Percent of clients abstinent from drugs	45.70%	77.88%

(2) If State does not have a "used any drug" variable, calculate instead using frequency of use variables for all primary, secondary, or tertiary problem codes in which the coded problem is Drugs (e.g., TEDS Codes 03-20)

State Description of Other Drug Use Data Collection (Form T5)

STATE CONFORMANCE TO INTERIM STANDARD	**States should detail exactly how this information is collected. Where data and methods vary from interim standard, variance should be described**
DATA SOURCE	**What is the source of data for table T5? (Select all that apply)** ☐ Client Self Report Client self-report confirmed by another source: ☐ urinalysis,blood test or other biological assay ☐ Collateral source ☐ Administrative data source ☐ Other: Specify
EPISODE OF CARE	**How is the admission/discharge basis defined for table T5? (Select one)** ○ Admission is on the first date of service, prior to which no service has bee received for 30 days AND discharge is on the last date of service, subsequent to which no service has been received for 30 days ○ Admission is on the first date of service in a Program/Service Delivery Unit and Discharge is on the last date of service in a Program/Service Delivery Unit ○ Other, Specify:
DISCHARGE DATA COLLECTION	**How was discharge data collected for table T5? (Select all that apply)** ☐ Not applicable, data reported on form is collected at time period other than discharge Specify: ○ In-Treatment data ____ days post admission ○ Follow-up data ____ months post admission ○ Other, Specify: ☐ Discharge data is collected for the census of all (or almost all) clients who were admitted to treatment ☐ Discharge data is collected for a sample of all clients who were admitted to treatment ☐ Discharge records are directly collected (or in the case of early dropouts) are created for all (or almost all) clients who were admitted to treatment ☐ Discharge records are not collected for approximately ____ % of clients who were admitted for

	treatment

RECORD LINKING	**Was the admission and discharge data linked for table T5? (Select all that apply)** ☐ Yes, all clients at admission were linked with discharge data using an Unique Client Identifier (UCID) Select type of UCID: ○ Master Client Index or Master Patient Index, centrally assigned ○ Social Security Number (SSN) ○ Unique client ID based on fixed client characteristics (such as date of birth, gender, partial SSN, etc.) ○ Some other Statewide unique ID ○ Provider-entity-specific unique ID ☐ No, State Management Information System does not utilize UCID that allows comparison of admission and discharge data on a client specific basis (data developed on a cohorts basis) or State relied on other data sources for post admission data ☐ No, admission and discharge records were matched using probabilistic record matching

IF DATA IS UNAVAILABLE	**If data is not reported, why is State unable to report? (Select all that apply)** ☐ Information is not collected at admission ☐ Information is not collected at discharge ☐ Information is not collected by the categories requested ☐ State collects information on the indicator area but utilizes a different measure.

DATA PLANS IF DATA IS NOT AVAILABLE	**State must provide time-framed plans for capturing drug abstinence data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and estimates of cost.**

Form T6

Most recent year for which data are available	From: 1/1/2008 To: 12/31/2008

Social Support of Recovery – Clients participating in self-help groups, support groups (e.g., AA, NA, etc.) (prior 30 days) at admission vs. discharge	Admission Clients (T_1)	Discharge Clients (T_2)
Number of clients with one or more such activities (AA NA meetings attended, etc.) [numerator]	22489	23973
Total number of Admission and Discharge clients with non-missing values on social support activities [denominator]	31276	31921
Percent of clients participating in social support activities	71.90%	75.10%

State Description of Social Support of Recovery Data Collection (Form T6)

STATE CONFORMANCE TO INTERIM STANDARD

States should detail exactly how this information is collected. Where data and methods vary from interim standard, variance should be described

DATA SOURCE

What is the source of data for table T6? (Select all that apply)

- ☐ Client Self Report
  - Client self-report confirmed by another source:
    - ☐ Collateral source
    - ☐ Administrative data source
- ☐ Other: Specify

EPISODE OF CARE

How is the admission/discharge basis defined for table T6? (Select one)

- ○ Admission is on the first date of service, prior to which no service has bee received for 30 days AND discharge is on the last date of service, subsequent to which no service has been received for 30 days
- ○ Admission is on the first date of service in a Program/Service Delivery Unit and Discharge is on the last date of service in a Program/Service Delivery Unit
- ○ Other, Specify:

DISCHARGE DATA COLLECTION

How was discharge data collected for table T6? (Select all that apply)

- ☐ Not applicable, data reported on form is collected at time period other than discharge
  - Specify:
    - ○ In-Treatment data ____ days post admission
    - ○ Follow-up data ____ months post admission
    - ○ Other, Specify:
- ☐ Discharge data is collected for the census of all (or almost all) clients who were admitted to treatment
- ☐ Discharge data is collected for a sample of all clients who were admitted to treatment
- ☐ Discharge records are directly collected (or in the case of early dropouts) are created for all (or almost all) clients who were admitted to treatment
- ☐ Discharge records are not collected for approximately ____ % of clients who were admitted for treatment

RECORD LINKING

Was the admission and discharge data linked for table T6? (Select all that apply)

- ☐ Yes, all clients at admission were linked with discharge data using an Unique Client Identifier (UCID)

	Select type of UCID: ○ Master Client Index or Master Patient Index, centrally assigned ○ Social Security Number (SSN) ○ Unique client ID based on fixed client characteristics (such as date of birth, gender, partial SSN, etc.) ○ Some other Statewide unique ID ○ Provider-entity-specific unique ID ☐ No, State Management Information System does not utilize UCID that allows comparison of admission and discharge data on a client specific basis (data developed on a cohorts basis) or State relied on other data sources for post admission data ☐ No, admission and discharge records were matched using probabilistic record matching

IF DATA IS UNAVAILABLE	**If data is not reported, why is State unable to report? (Select all that apply)** ☐ Information is not collected at admission ☐ Information is not collected at discharge ☐ Information is not collected by the categories requested ☐ State collects information on the indicator area but utilizes a different measure.

DATA PLANS IF DATA IS NOT AVAILABLE	**State must provide time-framed plans for capturing self-help participation status data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and estimates of cost.**

Counts reported here are from the “conducive environment” question which “Indicates if the client’s current living environment is supportive of recovery efforts associated with treatment.”

Form T7

Length of Stay (in Days) of All Discharges

Most recent year for which data are available	From: 1/1/2008 To: 12/31/2008

Length of Stay			
Level of Care	**Average**	**Median**	**Interquartile Range**
Detoxification (24-Hour Care)			
1. Hospital Inpatient			
2. Free-standing Residential	5.20	4	2
Rehabilitation / Residential			
3. Hospital Inpatient			
4. Short-term (up to 30 days)	32.10	29	2
5. Long-term (over 30 days)	78.50	60	31
Ambulatory (Outpatient)			
6. Outpatient	242.60	178	204
7. Intensive Outpatient	292.30	229	284
8. Detoxification			
Opioid Replacement Therapy (ORT)			
9. Opioid Replacement therapy	582.10	295	588

INSERT OVERALL NARRATIVE:

INSERT OVERALL NARRATIVE:

The State should address as many of these questions as possible and may provide other relevant information if so desired. Responses to questions that are already provided in other sections of the application (e.g., planning, needs assessment) should be referenced whenever possible.

State Performance Management and Leadership

Describe the Single State Agency's capacity and capability to make data driven decisions based on performance measures. Describe any potential barriers and necessary changes that would enhance the SSA's leadership role in this capacity.

Describe the types of regular and ad hoc reports generated by the State and identify to whom they are distributed and how.

If the State sets benchmarks, performance targets or quantified objectives, what methods are used by the State in setting these values?

What actions does the State take as a result of analyzing performance management data?

If the SSA has a regular training program for State and provider staff that collect and report client information, describe the training program, its participants and frequency.

Do workforce development plans address NOMs implementation and performance-based management practices?

Does the State require providers to supply information about the intensity or number of services received?

State of Washington
Division of Behavioral Health and Recovery
Overall Narrative

Mission

The Division of Behavioral Health and Recovery (DBHR) is the designated single-state agency charged with the delivery of substance abuse-related services in Washington State. DBHR is part of the Washington State Department of Social and Health Services (DSHS), and is a result of a merger of the former state Division of Alcohol and Substance Abuse and the former state Mental Health Division. This merger is designed to ensure better coordinated services for individuals with co-occurring substance abuse and mental health disorders.

DSHS' mission is to improve the safety and health of individuals, families and communities by providing leadership and establishing and participating in partnerships. DBHR shares DSHS' core values of excellence in service, respect, collaboration and partnership, diversity, and accountability. DBHR's mission is to promote strategies that support healthy lifestyles by preventing the misuse of alcohol, tobacco, and other drugs, and support recovery from the disease of chemical dependency. To succeed in its mission, DBHR is dedicated to building collaborative partnerships with communities, tribes, service providers, schools, colleges and universities, the criminal justice system, and other agencies within the private sector and within local, state, and federal governments. DBHR is committed to ensuring services are provided to individuals and communities in ways that are culturally relevant and honor the diversity of Washington State.

The Continuum of Care

DBHR is committed to articulating and integrating a full continuum of care to prevent the misuse of alcohol, tobacco, and other drugs, to serve individuals experiencing substance abuse problems, and to provide the support services necessary for them and their families to ensure recovery. In doing so, DBHR continues to improve its needs assessment and reporting capabilities, through its Prevention-Based Performance System (PBPS) , the Treatment and Assessment Report Generation Tool (TARGET) system, Healthy Youth Survey, CORE GIS, and linking with other state data systems encompassing all DSHS clients.

Prevention and Public Education Activities

DBHR supports youth prevention activities designed to reduce the incidence of substance abuse among Washington's youth. Utilizing an evidence-based risk-and-protective-factor framework, communities and schools pursue multiple strategies selected from science-based approaches designed to meet the prevention needs of their youth populations. Service delivery is contracted through counties (sub-state planning areas), tribes, schools, and educational service districts.

Programs include:

- School-based K-12 substance abuse curricula
- College- and university-based programs
- Education and support programs with children of substance users
- Peer support programs
- School staff intervention team programs
- Student assistance programs
- Community-based parenting training

- Community prevention taskforce development
- School and community taskforce training
- Mentoring

Special attention will be given to:

- Children transitioning between elementary and middle school, and between middle school and high school;
- Parents of young children;
- Children of chemically dependent or substance-abusing parents;
- School drop-outs; and
- Children exposed to illegal drug use and/or alcohol.

In contracts with county prevention providers, providers are required to use scientifically based best or promising practices for at least 50% of programming. Approximately 64% utilize best or promising practices. Among SFY 2009 prevention program participants, 22,969 individuals were in programs that utilized best practices, 3,230 in programs using promising approaches, and 2,559 in programs using innovative practices. Through its Performance-Based Prevention System, DBHR tracks both decreased use and increased abstinence from alcohol and drugs among prevention program participants. It is estimated that, over the lifetimes of participating youth, Washington State prevention programs implemented in SFY2009 saved $19.1 million.

DBHR participates in numerous cross-agency programs and initiatives by way of interagency agreements and partnerships with state agencies and non-profit organizations. These include:

- School-Based Prevention and Intervention Services Program
- Healthy Youth Survey
- Reducing Underage Drinking Initiative
- Reducing Access to Tobacco Products (Synar Regulation)
- College Coalition for Substance Abuse Prevention
- Children's Transition Initiative
- Alcohol/Drug Clearinghouse
- Exemplary Substance Abuse Prevention Awards
- Public Education and Communications Program
- Washington State Prevention Summit
- Drug-Free Communities

DBHR promotes prevention efforts aimed at populations other than youth. These include coordinating with higher education and campus-based groups to organize model programs pursuing drug-free campuses. DBHR also continue to support environmental prevention strategies, pharmaceutical drug take-back programs and prescription monitoring efforts to help the general population.

Intervention Efforts

DBHR offers an array of services aimed at reducing the risk of harm to individuals before substance abuse has developed into chemical dependency. Such services may be aimed at those who, whether chemically dependent or not, initially seek to decrease problem behaviors before they are prepared to be wholly abstinent from alcohol or other drugs.

Examples of intervention services include:

- School-based intervention services.
- Detoxification services, including referral to further treatment.
- Alcohol and drug information school for individuals convicted of driving-under-the-influence (DUI), but who are not assessed as having significant alcohol/drug problems.
- Helpline services.
- Counseling services provided to college students to help them reduce drinking.
- Brief interventions in hospital emergency departments, physicians' offices, and clinics.
- Drug courts, family therapeutic courts, and DUI courts.

As DBHR services become more fully integrated into the delivery of other health services, interventions are likely to become a more critical part of the continuum.

Student Assistance Prevention Intervention Services Program (SAPISP) – SAPISP is implemented by the state Office of Superintendent of Public Instruction with a mix of local, state, and federal specialists. In SFY 2009, 254 prevention intervention specialists were placed in 192 of the 295 Washington school districts, with between 600-800 schools receiving SAPISP services annually. An array of counseling, peer support groups, social skills training and individual and families prevention interventions are used to address the particular needs of each student. When the severity of use requires services that cannot be provided in the school setting, students are referred to chemical dependency treatment and other services in the community.

Alcohol/Drug Detoxification – In SFY 2009, there were 13,681 adult admissions to detoxification services. Detoxification for alcohol accounted for 58.9 percent of all detoxification admissions. Detoxification admissions for prescription-type opiates have increased from 395 in SFY 2004, to 1,252 in SFY 2009, representing a 217.0 percent increase. There has been a significant increase in the percentage of individuals entering treatment within 30 days of discharge from detoxification services, rising from 19.7 percent in SFY 2003-2005, to 29.6 percent in SFY 2007-2009, representing a 50.3 percent increase. There were 409 youth admissions to detoxification services in SFY 2009, 43.3 percent of which were for marijuana.

Brief Interventions at Colleges and Universities - In 2009, 17 Washington college and university campuses began use of e-Chug, an evidence-based approach to reducing substance abuse drawing on both motivational interviewing and social norms feedback theories. Several Washington State colleges and universities have implemented BASICS (Brief Alcohol Screening and Intervention for College Students), an evidence-based program design to motivate students to reduce alcohol use in order to decrease the negative consequences of drinking.

Treatment

DBHR provides a full array of treatment services. Levels of services are based on results from an assessment. After assessment, treatment plans are individualized and designed to maximize the probability of recovery, even as it is recognized that chemical dependency is a chronic, episodic disease.

Outpatient Treatment – In SFY 2009, there were 31,056 adult admissions to publicly funded outpatient/intensive outpatient treatment, representing 65.1 percent of all adult admission (excluding detoxification). This represents a 7.9 percent increase over SFY 2008, and a 42.3 percent increase since SFY 2004. In SFY 2008, 49.0 percent completed outpatient treatment, a significant improvement over 45.0 percent in SFY 2004. Outpatient treatment admissions are funded through county and tribal contracts.

Opiate Substitution Treatment – In SFY 2009, there were 2,324 admissions to publicly funded opiate substitution treatment, an increase of 20.7 percent over SFY 2008. During SFY 2008, 4,747 received publicly funded opiate substitution treatment. Of those served, 85.5 percent remained in treatment for at least six months, 76.6 percent remained in treatment for at least one year. Some 65 percent of those admitted in SFY 2008 reported heroin as their primary substance of abuse; 35 percent reported prescription-type opiates as their primary substance of abuse.

Intensive Inpatient Treatment – In SFY 2009, there were 10,805 adult admissions to publicly funded intensive inpatient treatment, representing a 3.3 percent increase over SFY 2008, and a 74.8 percent increase over SFY 2004. In SFY 2008, 77.5 percent completed treatment.

Recovery House – In SFY 2009, there were 712 adult admissions to publicly funded recovery house.

Long-Term Residential Treatment – In SFY 2009, there were 2,803 adult admissions to publicly funded long-term residential treatment, representing a 1.7 percent increase over SFY 2007, and a 34.1 percent increase over SFY 2004.

Youth Residential Treatment – In SFY 2009, there were 1,464 youth admissions to residential treatment, representing a 10.2 percent increase over SFY 2004. In SFY 2008, 74.3 percent of youth admitted completed residential treatment.

Youth Outpatient Treatment - In SFY 2009, there were 5,116 youth admissions to publicly funded outpatient/intensive outpatient treatment, a 3.1 percent increase over SFY 2008. In SFY 2008, 47.4 percent of youth admitted completed outpatient treatment.

In virtually every area, the number of individuals admitted to publicly funded treatment increased in SFY 2008, representing Washington State's sustained and increasing commitment to serving the needs of chemically dependent individuals. At the same time, length-of-stay in treatment and treatment completion have also been rising, representing an enhanced partnership between the DBHR, counties, tribes, and providers to ensure the quality of care.

There has been a substantial increase in the number of young adults (ages 18-24) entering publicly funded treatment, from 6,858 in SFY 2004, to 10,374 in SFY 2009, representing a 51.2 percent increase. During this period, there has been a substantial rise in those admitted for dependence on opiates (heroin and prescription-type opiates), representing 20.5 percent of all young adult admissions in SFY 2009. As a percentage of all adult admits, the percentage of young adults admitted to opiate substitution treatment (methadone) more than doubled, from 6.4 percent in SFY 2004, to 13.7 percent in SFY 2009.

Special efforts continue to be made to provide treatment services to: intravenous drug user, pregnant and parenting women, families with children, recipients of child welfare and child protective services, adolescents, ethnic minorities, individuals referred by the criminal justice system, injection drug users, persons with HIV/AIDS, and individuals with co-occurring mental health and substance abuse disorders. In SFY 2008:

- Racial and ethnic minorities represented 35 percent of adult admissions to publicly funded admissions to treatment, and 46 percent of youth admissions.
- Two-thirds of youth admitted to chemical dependency treatment in SFY 2008 were involved with the criminal justice system at time of admission.
- Approximately 14 percent of adult individuals admitted to treatment in SFY 2008 were homeless at time of admission.

- Some 29 percent of adults admitted to treatment had a co-occurring mental health disorder. Beginning in 2007, chemical dependency and mental health treatment providers began using a common co-occurring disorders screening instrument (GAIN-SS).
- Some 1,889 military veterans were admitted to treatment.
- 4,133 individuals received treatment through the state-funded Criminal Justice Treatment Account.
- 1,473 pregnant and parenting women received treatment. Of these, 37 percent had a co-occurring mental health disorder, and 25 percent received mental health treatment in the year prior to admission. Sixty percent had a history of being victims of domestic violence.

Recovery Support Services

DBHR recognizes that while treatment is critical for individuals who are chemically dependent to turn their lives around, aftercare and recovery support services are important adjuncts in helping to ensure individuals can move toward healthy lifestyles and return to active, productive lives in their families and communities. A recovery-oriented system of care builds upon the continuum of care in articulating the critical role an individual's home and community play in recovery, and the importance of expanding client choices in the recovery process.

Oxford Houses – Washington State leads the nation with 222 Oxford Houses, cooperative houses in the community that provide post-treatment housing to individuals who participate in recovery programs. Each house is alcohol- and drug-free, and is self-managed by the residents. There are several houses exclusively for women, and for parents with children. There are now about 1,900 Oxford House beds. Some 82 percent of residents remain in recovery for one year or longer. See Goal 7.

Parent Child Assistance Program (PCAP) – PCAP provides paraprofessional advocacy services to approximately 675 high-risk substance-abusing pregnant and parent women and young children in nine Washington counties and the Spokane Reservation. Services are available to women who are pregnant with or have given birth to a child prenatally exposed to alcohol and other drugs, women who themselves may have an FASD diagnosis, and high-risk women who received inadequate prenatal care and/or who have not successfully accessed community resources for substance abuse-affected families. In addition to referral, support, and advocacy for treatment, PCAP provides assistance in accessing and using local resources such as family planning, safe housing, health care, domestic violence services, parenting skills training, child welfare, childcare, transportation, and legal services. Linkages are made to health care and appropriate therapeutic interventions for children, as well as financial assistance for food, unmet health needs, and other necessities. See Goal 3.

Safe Babies Safe Moms annually serves approximately 250 substance-abusing pregnant, postpartum, and parenting women and their children from birth-to-three at sites in three counties. A specialized Targeted Intensive Case Management (TICM) multidisciplinary team serves each site, providing referral, support, and advocacy. TICM assists in accessing local resource, including family planning, safe housing, health care, domestic violence services, parenting skills training, child welfare, childcare, transportation, and legal services. Mental health screening, assessment, and treatment are provided as appropriate. Safe Babies Safe Moms works collaboratively with long-term residential chemical dependency treatment programs that provide a positive recovery environment, including therapeutic childcare for children. Following treatment, housing support services are provided, with transitional housing provided for up to 18 months. See Goal 3.

Quality and Workforce Development

DBHR conducts an annual statewide satisfaction survey at some 500 community-based and correctional treatment centers, with more than 22,000 patients taking part. Responses to the survey are sent to each of the respective treatment agencies for use in quality improvement activities. In 2009, 96% of adult and 91% of youth patients surveyed reported overall satisfaction with the service they received. See Goal 13.

DBHR maintains two database systems for use in tracking prevention and treatment activities: the Performance-Based Prevention System (PBPS), and the Treatment and Assessment Report Generation Tool (TARGET). Providers at the community level enter data about clients into each of the respective systems, and the systems are increasingly used to monitor outcomes of prevention and treatment activities. The TARGET system can provide aggregate data, for the entire state, by region, by county, and by program, in each modality, on patient demographics, substances of abuse, discharges and outcomes, family and social arrangements, legal involvement, and a full range of other indicators. It also allows DBHR to examine trends. Systems can be linked to other state health-related and criminal justice databases. Data about clients is accessible by the programs themselves, and can be used to monitor and evaluate local activities.

Peer Review

State financial constraints impacted the ability to conduct a Peer Review. This legislative session resulted in loss of our Citizens advisory council on Alcoholism and Drug Addiction, also known as CAC. The CAC had been instrumental in facilitating and overseeing the process for peer reviews. We have moved forward to develop an ad hoc group (consisting of former CAC members) within the Mental Health Planning and Advisory Council. This group will reestablish the protocol for conducting peer reviews. They will also continue to advise DBHR on the rules, policies, and programs that affect the chemical dependency field. See Goal 15.

Training

DBHR provides training and continuing education opportunities to more than 1,750 substance abuse professionals each year. These opportunities, provided through statewide conferences and local and regional trainings, utilizes a coordinated approach to address and promote workforce development and provide effective and high-quality clinical training. Trainings are designed to meet either specific needs as identified through counties strategic plans or are linked to statewide priorities or needs assessments. There are at least three statewide conferences each year: The Prevention Summit; Co-Occurring Disorders and Treatment Conference: and the "Saying It Out Loud" conference (which addresses the specific needs of sexual minorities.) Evaluations and outcomes of training activities are monitored. See Goal 11.

Certification

Over the past two years, the licensing and certification sections of the former Division of Alcohol and Substance Abuse and the former Mental Health Division have been merged. The merger has resulted in increased cross-training opportunities, and has streamlined licensing and certification for the more than 120 programs that are now dually certified, as well as providing enhanced technical assistance. All chemical dependency service providers must comply with agency certification requirements that ensure patient confidentiality and protect patient records from inappropriate disclosure.

State Performance Management and Leadership

- *Describe the Single State Authority capacity and capability to make data driven decisions based on performance measures? Describe any potential barriers and necessary changes that would enhance the SSA's leadership role in this capacity.*

DBHR has been a leader in data-driven decision-making. Specialized research studies undertaken by DBHR's Office of Evaluation and Quality Assurance have been used to document program outcomes and cost offsets. These studies are distributed to DBHR contract managers and to stakeholders throughout the state. A monthly management review document is prepared to monitor performance, comparing outputs and outcomes to pre-determined annual benchmarks and targets. Specific performance measures are developed related to treatment completion rates, and programs are monitored carefully, Completion rate reports for youth, adult, and PPW residential programs as well as outpatient programs are used by contract mangers to monitor programs and provide technical assistance where needed. Contract managers also review monthly data summaries, such as residential utilization reports and ad hoc analyses to guide funding and policy discussions and program development planning. The annual *Tobacco, Alcohol, and Other Drug Abuse Trends in Washington State* report provides background epidemiological and other data to inform decision packages and discussions with state policymakers.

All chemical dependency treatment providers are required to enter admission and discharge data into the Treatment and Assessment Report Generation Tool (TARGET). TARGET data are retrievable at the state, regional, county, and program level, and include complete information on demographics, family and social arrangements, diagnosis, substances of abuse, modalities, and other information, as well as completion and outcome data. TARGET can be linked with other statewide data bases to provide additional criminal justice and health-related information. Data is used to track trends, and inform decisions and recommendations to policymakers. With the merger between the Division of Alcohol and Substance Abuse and the Mental Health Division, new approaches to retrieving and managing client and provider data through a common data system. Efforts are underway to plan for effective use of these data systems to provide information necessary to ensure optimal treatment of co-occurring disorders.

DBHR's Performance-Based Prevention System (PBPS) provides data on all recurring prevention activities. Contractors are required to enter information related to participants and prevention activities. Pre- and post- surveys provide information on program effectiveness, which can then be used in further management and contracting decision-making.

- *Describe the types of regular and ad hoc reports generated by the State and identify to whom they are distributed and how.*

Contract managers and county contractors receive monthly reports from the TARGET system regarding the timeliness of reporting and the completion of discharge data reporting by contracted programs. The DBHR contract managers and county contractors receive monthly contract utilization reports as a tool for monitoring performance and to make management decisions regarding funding. DBHR contracts for services to provide a web-based treatment data analysis tool for contract staff and programs to create ad hoc reports. A monthly management review report is distributed to all management staff via e-mail, and is presented at a monthly meeting. The annual *Trends* report is distributed to staff, legislators, legislative analysts, and other agencies in both hardcopy and electronically, and is posted on DBHR's website. Reports from the Performance-Based Prevention System are distributed to prevention services contract managers, and made available to programs. Monthly reports from the Performance-Based Prevention System are distributed to prevention services contract managers regarding timeliness of reporting and the status of service delivery. Providers and DBHR contract managers also make use of ad hoc reports available through the Performance-Based Prevention System interface.

- *If the State sets benchmarks, performance targets or quantified objectives, what methods are used by the State in setting these values?*

The state sets performance targets via contract for client counts and funds expended. The values are set in collaboration with the contractors at the beginning of each contract period. The state considers past performance and other factors, such as client mix and geographic information (e.g. rural vs. urban) and distance of travel to a treatment center when setting performance targets. Specific benchmarks for treatment completion are also established for each modality of treatment based on historical performance and reasonable expectations from national studies. In addition, at least 50% of recurring prevention programs must meet the target of representing evidence-based practices

- *What actions does the State take as a result of analyzing performance management data?*

Performance targets are monitored on a monthly basis with contract reconciliation quarterly. Contracts are amended and performance measures are adjusted as needed. Technical assistance is provided to underperforming contractors. Performance data is increasingly used in the awarding of contracts.

- *Has the State developed evidence-based practices (EBPs) or programs and, if so, does the State require that providers use these EBPs?*

The state has not developed EBP's. However DBHR requires 50% of recurring prevention programs be EBP's. DBHR's Community Prevention Training (CPT) initiative provides financial support to county governments to increase their capacity to utilize EBPs. DBHR's annual State Prevention Summit also includes speakers promoting the use of EPBs. DBHR also encourages the use of EBP's in treatment programs, but they are not a contractual requirement at this time.

- *What actions does the State expect the provider or intermediary to take as a result of analyzing performance management data?*

Along with monitoring fund expenditures, the state also monitors performance benchmarks, including treatment completion and retention rates. If it is indicated that a provider is falling behind the state average, providers are expected with work with the state or other entity to develop a plan of action for improvement.

- *If the SSA has a regular training program for State and provider staff that collect and report client information, describe the training program, its participants and frequency.*

DBHR conducts training on a regular basis on data collection, data entry, and reporting. At least once a calendar quarter, in each of the six departmental regions throughout the state, a day-long training is provided on the TARGET systems, forms completion, and reporting. DBHR also provides a minimum of ten trainings a year on the use of the Prevention Management Information System called the Performance-Based Prevention System (PBPS).

- *Do workforce development plans address NOMs implementation and performance-based management practices?*

Workforce development plans do not directly address NOMs implementation. Washington has reported NOMS accurately for years, so this is not a priority need. Training in the treatment field currently emphasizes the use of common screening instruments for substance abuse and mental health disorders (GAIN-SS), and training to address the needs of patients with co-occurring disorders. In addition, given

the requirements of health care reform, workforce efforts are beginning to address the need for coordination/collaboration between the treatment field and primary care organizations. Ongoing workforce and training efforts address the quality of treatment which, in turns, drives measurable treatment outcomes.

DBHR has a Community Prevention Training (CPT) initiative that provides financial support to county governments to increase their capacity to utilize evidence-based prevention practices. Workforce development plans also include the Substance Abuse Prevention Specialists Training which teaches local providers how to best plan for prevention services to achieve optimum outcomes, including those risk and protective factors and prevalence measures that are part of the Prevention NOM's. DBHR's annual State Prevention Summit also includes speakers promoting the use of EPBs.

- *Does the State require providers to supply information about the intensity or number of services received?*

All providers who serve publicly funded patients must enter information into TARGET, the state chemical dependency treatment data system. This system collects encounter level data on the nature and duration of services delivered under public funding for all treatment services. PBPS collects similar information on the delivery of prevention services.

Treatment Corrective Action Plan (submit upon request)

1. Describe the corrective action plan, including critical steps and actions the State and its providers will employ to collect and report the National Outcome Measures data.

2. Discuss the timeframes for the State's corrective action plan detailing the planned milestones and other measures of progress the State has incorporated into its corrective action plan.

3. Describe the State's corrective action plan implementation monitoring activities including interventions or adjustments the State will employ when timeframes or milestones are not achieved.

This narrative response not included because it does not exist or has not yet been submitted.

Form P1
NOMs Domain: Reduced Morbidity—Abstinence from Drug Use/Alcohol Use
Measure: 30-Day Use

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
1. 30-day Alcohol Use	**Source Survey Item:** NSDUH Questionnaire. "Think specifically about the past 30 days, that is, from **[DATEFILL]** through today. During the past 30 days, on how many days did you drink one or more drinks of an alcoholic beverage?" [Response option: Write in a number between 0 and 30.] **Outcome Reported:** Percent who reported having used alcohol during the past 30 days.	Ages 12–17 - FFY 2008	16.20	
		Ages 18+ - FFY 2008	61.30	
2. 30-day Cigarette Use	**Source Survey Item:** NSDUH Questionnaire: "During the past 30 days, that is, since **[DATEFILL]**, on how many days did you smoke part or all of a cigarette?" [Response option: Write in a number between 0 and 30.] **Outcome Reported:** Percent who reported having smoked a cigarette during the past 30 days.	Ages 12–17 - FFY 2008	10.80	
		Ages 18+ - FFY 2008	23.40	
3. 30-day Use of Other Tobacco Products	**Source Survey Item:** NSDUH Questionnaire: "During the past 30 days, that is, since **[DATEFILL]**, on how many days did you use [other tobacco products] † ?" [Response option: Write in a number between 0 and 30.] **Outcome Reported:** Percent who reported having used a tobacco product other than cigarettes during the past 30 days, calculated by combining responses to questions about individual tobacco products (snuff, chewing tobacco, pipe tobacco).	Ages 12–17 - FFY 2008	7.10	
		Ages 18+ - FFY 2008	8.50	
4. 30-day Use of Marijuana	**Source Survey Item:** NSDUH Questionnaire: "Think specifically about the past 30 days, from **[DATEFILL]** up to and including today. During the past 30 days, on how many days did you use marijuana or hashish?" [Response option: Write in a number between 0 and 30.] **Outcome Reported:** Percent who reported having used marijuana or hashish during the past 30 days.	Ages 12–17 - FFY 2008	6.70	
		Ages 18+ - FFY 2008	8.20	
5. 30-day Use of Illegal Drugs Other Than Marijuana	**Source Survey Item:** NSDUH Questionnaire: "Think specifically about the past 30 days, from **[DATEFILL]** up to and including today. During the past 30 days, on how many days did you use [any other illegal drug] ‡ ?" **Outcome Reported:** Percent who reported having used illegal drugs other than marijuana or hashish during the past 30 days, calculated by combining responses to questions about individual drugs (heroin, cocaine, stimulants, hallucinogens, inhalants, prescription drugs used without doctors' orders).	Ages 12–17 - FFY 2008	4.80	
		Ages 18+ - FFY 2008	3.80	

((s)) Suppressed due to insufficient or non-comparable data

† NSDUH asks separate questions for each tobacco product. The number provided combines responses to all questions about tobacco products other than cigarettes.
‡ NSDUH asks separate questions for each illegal drug. The number provided combines responses to all questions about illegal drugs other than marijuana or hashish.

Form P2
NOMs Domain: Reduced Morbidity—Abstinence from Drug Use/Alcohol Use
Measure: Perception of Risk/Harm of Use

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
1. Perception of Risk From Alcohol	**Source Survey Item:** NSDUH Questionnaire: "How much do people risk harming themselves physically and in other ways when they have five or more drinks of an alcoholic beverage once or twice a week?" [Response options: No risk, slight risk, moderate risk, great risk] **Outcome Reported:** Percent reporting moderate or great risk.	Ages 12–17 - FFY 2008	76.10	
		Ages 18+ - FFY 2008	79.90	
2. Perception of Risk From Cigarettes	**Source Survey Item:** NSDUH Questionnaire: "How much do people risk harming themselves physically and in other ways when they smoke one or more packs of cigarettes per day?" [Response options: No risk, slight risk, moderate risk, great risk] **Outcome Reported:** Percent reporting moderate or great risk.	Ages 12–17 - FFY 2008	93.50	
		Ages 18+ - FFY 2008	95.30	
3. Perception of Risk From Marijuana	**Source Survey Item:** NSDUH Questionnaire: "How much do people risk harming themselves physically and in other ways when they smoke marijuana once or twice a week?" [Response options: No risk, slight risk, moderate risk, great risk] **Outcome Reported:** Percent reporting moderate or great risk.	Ages 12–17 - FFY 2008	75.30	
		Ages 18+ - FFY 2008	70	

((s)) Suppressed due to insufficient or non-comparable data

Form P3
NOMs Domain: Reduced Morbidity—Abstinence from Drug Use/Alcohol Use
Measure: Age of First Use

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
1. Age at First Use of Alcohol	**Source Survey Item:** NSDUH Questionnaire: "Think about the first time you had a drink of an alcoholic beverage. How old were you the first time you had a drink of an alcoholic beverage? Please do not include any time when you only had a sip or two from a drink." [Response option: Write in age at first use.] **Outcome Reported:** Average age at first use of alcohol.	Ages 12–17 - FFY 2008	13.10	
		Ages 18+ - FFY 2008	16.80	
2. Age at First Use of Cigarettes	**Source Survey Item:** NSDUH Questionnaire: "How old were you the first time you smoked part or all of a cigarette?" [Response option: Write in age at first use.] **Outcome Reported:** Average age at first use of cigarettes.	Ages 12–17 - FFY 2008	12.50	
		Ages 18+ - FFY 2008	15.60	
3. Age at First Use of Tobacco Products Other Than Cigarettes	**Source Survey Item:** NSDUH Questionnaire: "How old were you the first time you used [any other tobacco product] † ?" [Response option: Write in age at first use.] **Outcome Reported:** Average age at first use of tobacco products other than cigarettes.	Ages 12–17 - FFY 2008	13.90	
		Ages 18+ - FFY 2008	20.40	
4. Age at First Use of Marijuana or Hashish	**Source Survey Item:** NSDUH Questionnaire: "How old were you the first time you used marijuana or hashish?" [Response option: Write in age at first use.] **Outcome Reported:** Average age at first use of marijuana or hashish.	Ages 12–17 - FFY 2008	13.80	
		Ages 18+ - FFY 2008	17.60	
5. Age at First Use of Illegal Drugs Other Than Marijuana or Hashish	**Source Survey Item:** NSDUH Questionnaire: "How old were you the first time you used [other illegal drugs] ‡ ?" [Response option: Write in age at first use.] **Outcome Reported:** Average age at first use of other illegal drugs.	Ages 12–17 - FFY 2008	12.80	
		Ages 18+ - FFY 2008	19	

((s)) Suppressed due to insufficient or non-comparable data

† The question was asked about each tobacco product separately, and the youngest age at first use was taken as the measure.
‡ The question was asked about each drug in this category separately, and the youngest age at first use was taken as the measure.

Form P4
NOMs Domain: Reduced Morbidity—Abstinence from Drug Use/Alcohol Use
Measure: Perception of Disapproval/Attitudes

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
1. Disapproval of Cigarettes	**Source Survey Item:** NSDUH Questionnaire: "How do you feel about someone your age smoking one or more packs of cigarettes a day?" [Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove] **Outcome Reported:** Percent somewhat or strongly disapproving.	Ages 12–17 - FFY 2008	89.10	
2. Perception of Peer Disapproval of Cigarettes	**Source Survey Item:** NSDUH Questionnaire: "How do you think your close friends would feel about you smoking one or more packs of cigarettes a day?" [Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove] **Outcome Reported:** Percent reporting that their friends would somewhat or strongly disapprove.	Ages 12–17 - FFY 2008	88	
3. Disapproval of Using Marijuana Experimentally	**Source Survey Item:** NSDUH Questionnaire: "How do you feel about someone your age trying marijuana or hashish once or twice?" [Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove] **Outcome Reported:** Percent somewhat or strongly disapproving.	Ages 12–17 - FFY 2008	79.40	
4. Disapproval of Using Marijuana Regularly	**Source Survey Item:** NSDUH Questionnaire: "How do you feel about someone your age using marijuana once a month or more?" [Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove] **Outcome Reported:** Percent somewhat or strongly disapproving.	Ages 12–17 - FFY 2008	79.30	
5. Disapproval of Alcohol	**Source Survey Item:** NSDUH Questionnaire: "How do you feel about someone your age having one or two drinks of an alcoholic beverage nearly every day?" [Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove] **Outcome Reported:** Percent somewhat or strongly disapproving.	Ages 12–17 - FFY 2008	86.30	

((s)) Suppressed due to insufficient or non-comparable data

Form P5
NOMs Domain: Employment/Education
Measure: Perception of Workplace Policy

A. Measure	B. Question/Response		C. Pre-Populate Data	D. Approved Substitute Data
Perception of Workplace Policy	**Source Survey Item:** NSDUH Questionnaire: "Would you be more or less likely to want to work for an employer that tests its employees for drug or alcohol use on a random basis? Would you say more likely, less likely, or would it make no difference to you?" [Response options: More likely, less likely, would make no difference] **Outcome Reported:** Percent reporting that they would be more likely to work for an employer conducting random drug and alcohol tests.	Ages 18+ - FFY 2008	31.90	
		Ages 15–17 - FFY 2008	((s))	

((s)) Suppressed due to insufficient or non-comparable data

Form P6
NOMs Domain: Employment/Education
Measure: ATOD-Related Suspensions and Expulsions

. Measure	B. Question/Response		C. Pre-Populated Data	D. pproved Substitute Data
In Development	In Progress	In Progress	((s))	

((s)) Suppressed due to insufficient or non-comparable data

Form P7
NOMs Domain: Employment/Education
Measure: Average Daily School Attendance Rate

. Measure	B. Question/Response		C. Pre-Populate Data	D. pproved Su stitute Data
Average Daily School Attendance Rate	**Source:**National Center for Education Statistics, Common Core of Data: The National Public Education Finance Survey available for download at http://nces.ed.gov/ccd/stfis.asp **Measure calculation:** Average daily attendance (NCES defined) divided by total enrollment and multiplied by 100.	FFY 2008	92.30	

((s)) Suppressed due to insufficient or non-comparable data

Form P8
NOMs Domain: Crime and Criminal Justice
Measure: Alcohol-Related Traffic Fatalities

A. Measure	B. Question/Response		C. Pre Populated Data	D. Approved ubstitute Data
Alcohol-Related Traffic Fatalities	**Source:** National Highway Traffic Safety Administration Fatality Analysis Reporting System **Measure calculation:** The number of alcohol-related traffic fatalities divided by the total number of traffic fatalities and multiplied by 100.	FFY 2008	43.20	

((s)) Suppressed due to insufficient or non-comparable data

Form P9
NOMs Domain: Crime and Criminal Justice
Measure: Alcohol- and Drug-Related Arrests

A. Measure	B. Question/Response		C. Pre Populated Data	D. Approved ubstitute Data
Alcohol- and Drug-Related Arrests	**Source:** Federal Bureau of Investigation Uniform Crime Reports **Measure calculation:** The number of alcohol- and drug-related arrests divided by the total number of arrests and multiplied by 100.	FFY 2008	107.40	

((s)) Suppressed due to insufficient or non-comparable data

Form P10
NOMs Domain: Social Connectedness
Measure: Family Communications Around Drug and Alcohol Use

. Measure	B. Question/Response		C. Pre-Populat Data	D. pprov Substitut Data
1. Family Communications Around Drug and Alcohol Use (Youth)	**Source Survey Item:** NSDUH Questionnaire: "Now think about the past 12 months, that is, from **[DATEFILL]** through today. During the past 12 months, have you talked with at least one of your parents about the dangers of tobacco, alcohol, or drug use? By parents, we mean either your biological parents, adoptive parents, stepparents, or adult guardians, whether or not they live with you." [Response options: Yes, No] **Outcome Reported:** Percent reporting having talked with a parent.	Ages 12–17 - FFY 2008	61.90	
2. Family Communications Around Drug and Alcohol Use (Parents of children aged 12– 17)	**Source Survey Item:** NSDUH Questionnaire: "During the past 12 months, how many times have you talked with your child about the dangers or problems associated with the use of tobacco, alcohol, or other drugs?" † [Response options: 0 times, 1 to 2 times, a few times, many times] **Outcome Reported:** Percent of parents reporting that they have talked to their child.	Ages 18+ - FFY 2008	((s))	

((s)) Suppressed due to insufficient or non-comparable data

† NSDUH does not ask this question of all sampled parents. It is a validation question posed to parents of 12- to 17-year-old survey respondents. Therefore, the responses are not representative of the population of parents in a State. The sample sizes are often too small for valid reporting.

Form P11
NOMs Domain: Retention
Measure: Percentage of Youth Seeing, Reading, Watching, or Listening to a Prevention Message

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
Exposure to Prevention Messages	**Source Survey Item:** NSDUH Questionnaire: "During the past 12 months, do you recall [hearing, reading, or watching an advertisement about the prevention of substance use] † ?" **Outcome Reported:** Percent reporting having been exposed to prevention message.	Ages 12–17 - FFY 2008	92.20	

((s)) Suppressed due to insufficient or non-comparable data

† This is a summary of four separate NSDUH questions each asking about a specific type of prevention message delivered within a specific context.

P-Forms 12a- P-15 – Reporting Period

Reporting Period - Start and End Dates for Information Reported on Forms P12A, P12B, P13, P14 and P15

Forms	A. Reporting Period Start Date	B. Reporting Period End Date
Form P12a Individual-Based Programs and Strategies—Number of Persons Served by Age, Gender, Race, and Ethnicity	1/1/2008	12/31/2008
Form P12b Population-Based Programs and Strategies—Number of Persons Served by Age, Gender, Race, and Ethnicity	1/1/2008	12/31/2008
Form P13 (Optional) Number of Persons Served by Type of Intervention	1/1/2008	12/31/2008
Form P14 Number of Evidence-Based Programs and Strategies by Type of Intervention	1/1/2008	12/31/2008
Form P15 FY 2008 Total Number of Evidence Based Programs and Total SAPT BG Dollars Spent on Evidence-Based Programs/Strategies	1/1/2008	12/31/2008

Calendar year 2008 dates established early in the process. All Prevention MIS (PBPS) information provided for this application falls within these dates. -Aaron 3-Sept-2010

Form P12a
Individual-Based Programs and Strategies—Number of Persons Served by Age, Gender, Race, and Ethnicity

Question 1: Describe the data collection system you used to collect the NOMs data (e.g., MDS, DbB, KIT Solutions, manual process).

DBHR contracts with KIT Solutions LLC for its web-based prevention MIS (PBPS). All SAPT Block Grant funded prevention providers report administrative, service, and outcome data into the PBPS monthly.

Question 2: Describe how your State's data collection and reporting processes record a participant's race, specifically for participants who are more than one race.

'Multiracial' is an option for participants. Participants are not asked to provide details on the specific races. The Prevention MIS will not allow entry of more than one answer for the Race item.

Category	Description	Total Served
A. Age	1. 0-4	431
	2. 5-11	15417
	3. 12-14	16204
	4. 15-17	10327
	5. 18-20	1363
	6. 21-24	443
	7.25-44	2352
	8. 45-64	1206
	9. 65 And Over	116
	10. Age Not Known	71
B. Gender	Male	22896
	Female	25034
	Gender Unknown	0
C. Race	White	35434
	Black or African American	1717
	Native Hawaiian/Other Pacific Islander	529
	Asian	1108
	American indian/Alaska Native	2826
	More Than One Race (not OMB required)	3984
	Race Not Known or Other (not OMB required)	2332
D. Ethnicity	Hispanic or Latino	8123
	Not Hispanic or Latino	39806
	Ethnicity Unknown	0

Individual services are counted as the sum of participants in Indirect, Selective, Universal Direct.

As allowed by the form description, there is duplication where a participant is participated in more than one program.

Age Unknown caused by data entry errors. Typically either a birthdate value was entered that was greater than the first date of service (in the future), or "today's date" accidentally entered as birthdate.

==Following code used to generate data set==

```
--ALL Participants in recurring services in CY 2008
SELECT service.parentorgid as organizationid, Attendance.ClientID, Service.ProgramID,
Service.GroupID
into #temp1
FROM Attendance RIGHT OUTER JOIN
Service ON Attendance.EventID = Service.EventID
WHERE (Service.SVdate BETWEEN CONVERT(DATETIME, '2008-01-01 00:00:00', 102) AND
CONVERT(DATETIME, '2008-12-31 00:00:00', 102))
        AND attendance.Clientid is not null
GROUP BY service.parentorgid, Attendance.ClientID, Service.ProgramID, Service.GroupID

--add demographic information to #temp1
Select a.*, CONVERT(DATETIME, c.birthdate, 102) as birthdate, c.race, c.sex, c.ethnicity
into #temp2
from #temp1 a
   LEFT OUTER JOIN client as c on a.clientid = c.clientid

--get first date of service in CY2008 for each program-group
Select convert(DATETIME, min(SVDate), 102) as firstDate, Programid, groupid, parentorgid
into #temp3 from service
Where SVdate BETWEEN CONVERT(DATETIME, '2008-01-01 00:00:00', 102) AND
CONVERT(DATETIME, '2008-12-31 00:00:00', 102)
Group by programid, groupid, parentorgid

--put client demographics (#temp2) together with first date of service (#temp3)
-- date is null, substitute start date
select a.*, isnull(b.firstDate, convert(DATETIME, '2009-01-01 00:00:00', 102)) as firstdate
into #temp4
from #temp2 as a
   LEFT OUTER JOIN #temp3 as b on a.programid = b.programid and a.groupid = b.groupid and
a.organizationid = b.parentorgid


--calculate age range and put labels on demographics
select a.*, r.racecat, e.evalue, g.gender,
case when FLOOR((DATEDIFF(d, convert(datetime, a.BIRTHDATE, 102), convert(datetime,
a.firstdate, 102))) / 365.25) between 0 and 4 then '0-4'
```

```
when FLOOR((DATEDIFF(d, convert(datetime, a.BIRTHDATE, 102), convert(datetime, a.firstdate,
102))) / 365.25) between 5 and 11 then '5-11'
when FLOOR((DATEDIFF(d, convert(datetime, a.BIRTHDATE, 102), convert(datetime, a.firstdate,
102))) / 365.25) between 12 and 14 then '12-14'
when FLOOR((DATEDIFF(d, convert(datetime, a.BIRTHDATE, 102), convert(datetime, a.firstdate,
102))) / 365.25) between 15 and 17 then '15-17'
when FLOOR((DATEDIFF(d, convert(datetime, a.BIRTHDATE, 102), convert(datetime, a.firstdate,
102))) / 365.25) between 18 and 20 then '18-20'
when FLOOR((DATEDIFF(d, convert(datetime, a.BIRTHDATE, 102), convert(datetime, a.firstdate,
102))) / 365.25) between 21 and 24 then '21-24'
when FLOOR((DATEDIFF(d, convert(datetime, a.BIRTHDATE, 102), convert(datetime, a.firstdate,
102))) / 365.25) between 25 and 44 then '25-44'
when FLOOR((DATEDIFF(d, convert(datetime, a.BIRTHDATE, 102), convert(datetime, a.firstdate,
102))) / 365.25) between 45 and 64 then '45-64'
when FLOOR((DATEDIFF(d, convert(datetime, a.BIRTHDATE, 102), convert(datetime, a.firstdate,
102))) / 365.25) > 64 then '65+'
else 'unknown' end ageRange
into #temp5
from #temp4 a
    LEFT OUTER JOIN indxRace r on a.race = r.racecode
    LEFT OUTER JOIN indxEthnicity e on a.ethnicity = e.ecode
    LEFT OUTER JOIN indxGender g on a.sex = g.genderid


--add IOM type to determine whether it's an individual or population based program.
-- still using client data so it's limited to recurring services so far.
select distinct a.programid, a.groupid, a.organizationid, p.ptypeid, t.ptype as IOM, 'recurring' as
mode
into #temp6
from #temp4 a
    LEFT OUTER JOIN program p on a.programid = p.programid and a.organizationid =
p.organizationid
    LEFT OUTER JOIN indxProgType t on p.ptypeid = t.ptypeid

--put #temp5 and #temp6 together into a table for prep to mulitple pivots for each demographic
category
select a.programid, a.racecat, a.evalue, a.gender, a.agerange, b.IOM, b.mode, clientid
into #tempPivot
from #Temp5 a
    INNER JOIN #temp6 b on a.programid = b.programid and a.organizationid = b.organizationid and
a.groupid = b.groupid

--BUILD PIVOTS FOR EACH SUBCATEGORY TO CREATE A FLAT FILE
--race pivot
select programid, mode, iom, racecat, clientid into #tempRaceP from #tempPivot
select * into #pivotRace from #tempRaceP
pivot ( count(clientid) for racecat in( [Multiracial], [African American/Black], [Native Hawaiian or
Pacific Islander], [American Indian or Alaska Native],
```

```
[White/European American], [Asian/Asian American], [Other])) as p
--age range
select programid, agerange, clientid into #tempAgeP from #tempPivot
select * into #pivotAge from #tempAgeP
pivot ( count(clientid) for agerange in([unknown], [12-14], [0-4],[15-17], [45-64], [65+], [25-44], [21-
24], [5-11], [18-20] )) as p
--ethnicity
select programid, evalue, clientid into #tempEthnicityP from #tempPivot
select * into #pivotEthnicity from #tempEthnicityP
pivot ( count(clientid) for evalue in([Not Hispanic or Latino], [Hispanics or Latinos], [NULL] )) as p
--sex
select programid, gender, clientid into #tempgenderP from #tempPivot
select * into #pivotSex from #tempgenderP
pivot ( count(clientid) for gender in([female], [male] )) as p

--join the pivots back together using programid
Select a.mode, a.iom, a.[Multiracial], a.[African American/Black], a.[Native Hawaiian or Pacific
Islander],
a.[American Indian or Alaska Native], a.[White/European American], a.[Asian/Asian American],
a.[Other],
b.[unknown] as UnkAge, b.[0-4], b.[5-11], b.[12-14], b.[15-17], b.[18-20], b.[21-24], b.[25-44],
b.[45-64], b.[65+], c.[Not Hispanic or Latino], c.[Hispanics or Latinos], d.[female], d.[male]
into #finalRecurring
FROM #pivotRace a
    LEFT OUTER JOIN #pivotAge b on a.programid = b.programid
    LEFT OUTER JOIN #pivotEthnicity c on a.programid = c.programid
    LEFT OUTER JOIN #pivotSex d on a.programid = d.programid


drop table #tempRaceP
drop table #tempAgeP
drop table #tempEthnicityP
drop table #tempgenderP
drop table #pivotRace
drop table #pivotAge
drop table #pivotEthnicity
drop table #pivotSex



/* DONE WITH RECURRING, now to Single Services */


--SINGLE SERVICE DEMOGRAPHICS
SELECT p.OrganizationID, a.ProgramID, a.GroupID, t.ptype as IOM, 'single' as mode,
Sum(d.Ethnicity1) AS [Hispanics or Latinos],
Sum(d.Ethnicity2) AS [Not Hispanics or Latinos],
Sum(d.Race4) AS [Asian/Asian American],
```

```
Sum(d.Race2) AS [African American/Black],
Sum(d.Race5) AS Multiracial,
Sum(d.Race3) AS [American Indian or Alaska Native],
Sum(d.Race7) AS Other,
Sum(d.Race6) AS [Native Hawaiian or Pacific Islander],
Sum(d.Race1) AS [White/European American],
Sum(d.GenderFemale) AS female,
Sum(d.GenderMale) AS male,
Sum(d.AgeGroup1) AS [0-4],
Sum(d.AgeGroup2) AS [5-11],
Sum(d.AgeGroup3) AS [12-14],
Sum(d.AgeGroup4) AS [15-17],
Sum(d.AgeGroup5) AS [18-20],
Sum(d.AgeGroup6) AS [21-24],
Sum(d.AgeGroup7) AS [25-44],
Sum(d.AgeGroup8) AS [45-64],
Sum(d.AgeGroup9) AS [65+],
null as [unkAge]
into #temp7
FROM Service a
    INNER JOIN SingleServiceDemographics d ON a.EventID = d.EventID
    INNER JOIN Program p on a.programid = p.programid and a.parentorgid = p.organizationid
        INNER JOIN indxProgType t on p.ptypeid = t.ptypeid
Where SVdate BETWEEN CONVERT(DATETIME, '2008-01-01 00:00:00', 102) AND
CONVERT(DATETIME, '2008-12-31 00:00:00', 102)
GROUP BY p.OrganizationID, a.ProgramID, a.GroupID, t.ptype


/* Some programs have both single and recurring services. Where the single services have a ton of
people, change IOM to universal indirect.
If single service is Indicated, Selective, or Universal Direct and has huge population, change to
Universal Indirect. */
Select *,
CASE WHEN ((IOM = 'Universal Direct') AND (Male + Female > 300)) then 'Universal Indirect'
WHEN (IOM in('Indicated', 'Selective')) then 'Universal Indirect'
Else IOM end IOMa
INto #temp7a
FROM #temp7

SELECT mode, IOMa as IOM, [Multiracial], [African American/Black], [Native Hawaiian or Pacific
Islander],
[American Indian or Alaska Native],[White/European American], [Asian/Asian American], [Other],
[unkAge], [0-4], [5-11], [12-14], [15-17], [18-20], [21-24], [25-44], [45-64], [65+],
[Not Hispanics or Latinos], [Hispanics or Latinos], female, male
into #finalSingle
from #temp7a

select * into #tempfinal from (
```

```
select * from #finalrecurring
UNION SELECT * from #finalsingle) as p


select iom, sum([Multiracial]) as multiracial,
sum([African American/Black]) as black,
sum([Native Hawaiian or Pacific Islander]) as pacific,
sum([American Indian or Alaska Native]) as [native],
sum([White/European American]) as white,
sum([Asian/Asian American]) as asian,
sum([Other]) as [otherRace],
sum([unkAge]) as unkAge,
sum([0-4]) as [0-4],
sum([5-11]) as [5-11],
sum([12-14]) as [12-14],
sum([15-17]) as [15-17],
sum([18-20]) as [18-20],
sum([21-24]) as [21-24],
sum([25-44]) as [25-44],
sum([45-64]) as [45-64],
sum([65+]) as [65+],
sum([Not Hispanic or Latino]) as [Not Hispanic or Latino],
sum([Hispanics or Latinos]) as [Hispanics or Latinos],
sum(female) as female,
sum(male) as male
from #tempfinal
group by iom

/* FORM 12a */
--select sum([Multiracial]) as multiracial,
--sum([African American/Black]) as black,
--sum([Native Hawaiian or Pacific Islander]) as pacific,
--sum([American Indian or Alaska Native]) as [native],
--sum([White/European American]) as white,
--sum([Asian/Asian American]) as asian,
--sum([Other]) as [otherRace],
--sum([unkAge]) as unkAge,
--sum([0-4]) as [0-4],
--sum([5-11]) as [5-11],
--sum([12-14]) as [12-14],
--sum([15-17]) as [15-17],
--sum([18-20]) as [18-20],
--sum([21-24]) as [21-24],
--sum([25-44]) as [25-44],
--sum([45-64]) as [45-64],
--sum([65+]) as [65+],
--sum([Not Hispanic or Latino]) as [Not Hispanic or Latino],
--sum([Hispanics or Latinos]) as [Hispanics or Latinos],
```

```
--sum(female) as female,
--sum(male) as male
--from #tempfinal
--WHERE iom not in('universal indirect')


--select p.programname, a.*
--from #finalSingle a inner join program p on a.programid = p.programid and a.organizationid =
p.organizationid
--where a.female + a.male > 100 --and a.IOM not like 'Univ%'


drop table #temp1
drop table #temp2
drop table #temp3
drop table #temp4
drop table #temp5
drop table #temp6
drop table #tempPivot
drop table #temp7
drop table #temp7a
drop table #finalrecurring
drop table #finalsingle
drop table #tempfinal
```

Form 12b
Population-Based Programs and Strategies—Number of Persons Served by Age, Gender, Race, and Ethnicity

Category	Description	Total Served
A. Age	1. 0-4	27805
	2. 5-11	47637
	3. 12-14	32218
	4. 15-17	35024
	5. 18-20	31293
	6. 21-24	34867
	7.25-44	119966
	8. 45-64	109762
	9. 65 And Over	46588
	10. Age Not Known	5
B. Gender	Male	239412
	Female	245753
	Gender Unknown	0
C. Race	White	314232
	Black or African American	13347
	Native Hawaiian/Other Pacific Islander	10049
	Asian	16159
	American indian/Alaska Native	8738
	More Than One Race (not OMB required)	66749
	Race Not Known or Other (not OMB required)	55891
D. Ethnicity	Hispanic or Latino	92072
	Not Hispanic or Latino	393093
	Ethnicity Unknown	0

Population-based programs defined as Universal Indirect.

66,749 "Multiracial" primarily entered by tribal community programs.
55,891 "Other or Unknown" entered as "Other" in Prevention MIS. Primarily programs service Hispanics/Latinos.

Community Coordination activities do not record service populations. Used the 2008 OFM population estimate to distribute population across categories.

==Following code used to generate data set for Single and Recurring programs==

```
--ALL Participants in recurring services in CY 2008
SELECT service.parentorgid as organizationid, Attendance.ClientID, Service.ProgramID,
Service.GroupID
into #temp1
FROM Attendance RIGHT OUTER JOIN
Service ON Attendance.EventID = Service.EventID
WHERE (Service.SVdate BETWEEN CONVERT(DATETIME, '2008-01-01 00:00:00', 102) AND
CONVERT(DATETIME, '2008-12-31 00:00:00', 102))
        AND attendance.Clientid is not null
GROUP BY service.parentorgid, Attendance.ClientID, Service.ProgramID, Service.GroupID

--add demographic information to #temp1
Select a.*, CONVERT(DATETIME, c.birthdate, 102) as birthdate, c.race, c.sex, c.ethnicity
into #temp2
from #temp1 a
   LEFT OUTER JOIN client as c on a.clientid = c.clientid

--get first date of service in CY2008 for each program-group
Select convert(DATETIME, min(SVDate), 102) as firstDate, Programid, groupid, parentorgid
into #temp3 from service
Where SVdate BETWEEN CONVERT(DATETIME, '2008-01-01 00:00:00', 102) AND
CONVERT(DATETIME, '2008-12-31 00:00:00', 102)
Group by programid, groupid, parentorgid

--put client demographics (#temp2) together with first date of service (#temp3)
-- date is null, substitute start date
select a.*, isnull(b.firstDate, convert(DATETIME, '2009-01-01 00:00:00', 102)) as firstdate
into #temp4
from #temp2 as a
   LEFT OUTER JOIN #temp3 as b on a.programid = b.programid and a.groupid = b.groupid and
a.organizationid = b.parentorgid


--calculate age range and put labels on demographics
select a.*, r.racecat, e.evalue, g.gender,
case when FLOOR((DATEDIFF(d, convert(datetime, a.BIRTHDATE, 102), convert(datetime,
```

```
a.firstdate, 102))) / 365.25) between 0 and 4 then '0-4'
when FLOOR((DATEDIFF(d, convert(datetime, a.BIRTHDATE, 102), convert(datetime, a.firstdate,
102))) / 365.25) between 5 and 11 then '5-11'
when FLOOR((DATEDIFF(d, convert(datetime, a.BIRTHDATE, 102), convert(datetime, a.firstdate,
102))) / 365.25) between 12 and 14 then '12-14'
when FLOOR((DATEDIFF(d, convert(datetime, a.BIRTHDATE, 102), convert(datetime, a.firstdate,
102))) / 365.25) between 15 and 17 then '15-17'
when FLOOR((DATEDIFF(d, convert(datetime, a.BIRTHDATE, 102), convert(datetime, a.firstdate,
102))) / 365.25) between 18 and 20 then '18-20'
when FLOOR((DATEDIFF(d, convert(datetime, a.BIRTHDATE, 102), convert(datetime, a.firstdate,
102))) / 365.25) between 21 and 24 then '21-24'
when FLOOR((DATEDIFF(d, convert(datetime, a.BIRTHDATE, 102), convert(datetime, a.firstdate,
102))) / 365.25) between 25 and 44 then '25-44'
when FLOOR((DATEDIFF(d, convert(datetime, a.BIRTHDATE, 102), convert(datetime, a.firstdate,
102))) / 365.25) between 45 and 64 then '45-64'
when FLOOR((DATEDIFF(d, convert(datetime, a.BIRTHDATE, 102), convert(datetime, a.firstdate,
102))) / 365.25) > 64 then '65+'
else 'unknown' end ageRange
into #temp5
from #temp4 a
    LEFT OUTER JOIN indxRace r on a.race = r.racecode
    LEFT OUTER JOIN indxEthnicity e on a.ethnicity = e.ecode
    LEFT OUTER JOIN indxGender g on a.sex = g.genderid


--add IOM type to determine whether it's an individual or population based program.
-- still using client data so it's limited to recurring services so far.
select distinct a.programid, a.groupid, a.organizationid, p.ptypeid, t.ptype as IOM, 'recurring' as
mode
into #temp6
from #temp4 a
    LEFT OUTER JOIN program p on a.programid = p.programid and a.organizationid =
p.organizationid
    LEFT OUTER JOIN indxProgType t on p.ptypeid = t.ptypeid

--put #temp5 and #temp6 together into a table for prep to mulitple pivots for each demographic
category
select a.programid, a.racecat, a.evalue, a.gender, a.agerange, b.IOM, b.mode, clientid
into #tempPivot
from #Temp5 a
    INNER JOIN #temp6 b on a.programid = b.programid and a.organizationid = b.organizationid and
a.groupid = b.groupid

--BUILD PIVOTS FOR EACH SUBCATEGORY TO CREATE A FLAT FILE
--race pivot
select programid, mode, iom, racecat, clientid into #tempRaceP from #tempPivot
select * into #pivotRace from #tempRaceP
pivot ( count(clientid) for racecat in( [Multiracial], [African American/Black], [Native Hawaiian or
```

```
Pacific Islander], [American Indian or Alaska Native],
[White/European American], [Asian/Asian American], [Other])) as p
--age range
select programid, agerange, clientid into #tempAgeP from #tempPivot
select * into #pivotAge from #tempAgeP
pivot ( count(clientid) for agerange in([unknown], [12-14], [0-4],[15-17], [45-64], [65+], [25-44], [21-
24], [5-11], [18-20] )) as p
--ethnicity
select programid, evalue, clientid into #tempEthnicityP from #tempPivot
select * into #pivotEthnicity from #tempEthnicityP
pivot ( count(clientid) for evalue in([Not Hispanic or Latino], [Hispanics or Latinos], [NULL] )) as p
--sex
select programid, gender, clientid into #tempgenderP from #tempPivot
select * into #pivotSex from #tempgenderP
pivot ( count(clientid) for gender in([female], [male] )) as p

--join the pivots back together using programid
Select a.mode, a.iom, a.[Multiracial], a.[African American/Black], a.[Native Hawaiian or Pacific
Islander],
a.[American Indian or Alaska Native], a.[White/European American], a.[Asian/Asian American],
a.[Other],
b.[unknown] as UnkAge, b.[0-4], b.[5-11], b.[12-14], b.[15-17], b.[18-20], b.[21-24], b.[25-44],
b.[45-64], b.[65+], c.[Not Hispanic or Latino], c.[Hispanics or Latinos], d.[female], d.[male]
into #finalRecurring
FROM #pivotRace a
    LEFT OUTER JOIN #pivotAge b on a.programid = b.programid
    LEFT OUTER JOIN #pivotEthnicity c on a.programid = c.programid
    LEFT OUTER JOIN #pivotSex d on a.programid = d.programid


drop table #tempRaceP
drop table #tempAgeP
drop table #tempEthnicityP
drop table #tempgenderP
drop table #pivotRace
drop table #pivotAge
drop table #pivotEthnicity
drop table #pivotSex



/* DONE WITH RECURRING, now to Single Services */


--SINGLE SERVICE DEMOGRAPHICS
SELECT p.OrganizationID, a.ProgramID, a.GroupID, t.ptype as IOM, 'single' as mode,
Sum(d.Ethnicity1) AS [Hispanics or Latinos],
Sum(d.Ethnicity2) AS [Not Hispanics or Latinos],
```

```
Sum(d.Race4) AS [Asian/Asian American],
Sum(d.Race2) AS [African American/Black],
Sum(d.Race5) AS Multiracial,
Sum(d.Race3) AS [American Indian or Alaska Native],
Sum(d.Race7) AS Other,
Sum(d.Race6) AS [Native Hawaiian or Pacific Islander],
Sum(d.Race1) AS [White/European American],
Sum(d.GenderFemale) AS female,
Sum(d.GenderMale) AS male,
Sum(d.AgeGroup1) AS [0-4],
Sum(d.AgeGroup2) AS [5-11],
Sum(d.AgeGroup3) AS [12-14],
Sum(d.AgeGroup4) AS [15-17],
Sum(d.AgeGroup5) AS [18-20],
Sum(d.AgeGroup6) AS [21-24],
Sum(d.AgeGroup7) AS [25-44],
Sum(d.AgeGroup8) AS [45-64],
Sum(d.AgeGroup9) AS [65+],
null as [unkAge]
into #temp7
FROM Service a
   INNER JOIN SingleServiceDemographics d ON a.EventID = d.EventID
   INNER JOIN Program p on a.programid = p.programid and a.parentorgid = p.organizationid
      INNER JOIN indxProgType t on p.ptypeid = t.ptypeid
Where SVdate BETWEEN CONVERT(DATETIME, '2008-01-01 00:00:00', 102) AND
CONVERT(DATETIME, '2008-12-31 00:00:00', 102)
GROUP BY p.OrganizationID, a.ProgramID, a.GroupID, t.ptype


/* Some programs have both single and recurring services. Where the single services have a ton of
people, change IOM to universal indirect.
If single service is Indicated, Selective, or Universal Direct and has huge population, change to
Universal Indirect. */
Select *,
CASE WHEN ((IOM = 'Universal Direct') AND (Male + Female > 300)) then 'Universal Indirect'
WHEN (IOM in('Indicated', 'Selective')) then 'Universal Indirect'
Else IOM end IOMa
INto #temp7a
FROM #temp7

SELECT mode, IOMa as IOM, [Multiracial], [African American/Black], [Native Hawaiian or Pacific
Islander],
[American Indian or Alaska Native],[White/European American], [Asian/Asian American], [Other],
[unkAge], [0-4], [5-11], [12-14], [15-17], [18-20], [21-24], [25-44], [45-64], [65+],
[Not Hispanics or Latinos], [Hispanics or Latinos], female, male
into #finalSingle
from #temp7a
```

```
select * into #tempfinal from (
select * from #finalrecurring
UNION SELECT * from #finalsingle) as p


select iom, sum([Multiracial]) as multiracial,
sum([African American/Black]) as black,
sum([Native Hawaiian or Pacific Islander]) as pacific,
sum([American Indian or Alaska Native]) as [native],
sum([White/European American]) as white,
sum([Asian/Asian American]) as asian,
sum([Other]) as [otherRace],
sum([unkAge]) as unkAge,
sum([0-4]) as [0-4],
sum([5-11]) as [5-11],
sum([12-14]) as [12-14],
sum([15-17]) as [15-17],
sum([18-20]) as [18-20],
sum([21-24]) as [21-24],
sum([25-44]) as [25-44],
sum([45-64]) as [45-64],
sum([65+]) as [65+],
sum([Not Hispanic or Latino]) as [Not Hispanic or Latino],
sum([Hispanics or Latinos]) as [Hispanics or Latinos],
sum(female) as female,
sum(male) as male
from #tempfinal
group by iom

/* FORM 12b */
--select sum([Multiracial]) as multiracial,
--sum([African American/Black]) as black,
--sum([Native Hawaiian or Pacific Islander]) as pacific,
--sum([American Indian or Alaska Native]) as [native],
--sum([White/European American]) as white,
--sum([Asian/Asian American]) as asian,
--sum([Other]) as [otherRace],
--sum([unkAge]) as unkAge,
--sum([0-4]) as [0-4],
--sum([5-11]) as [5-11],
--sum([12-14]) as [12-14],
--sum([15-17]) as [15-17],
--sum([18-20]) as [18-20],
--sum([21-24]) as [21-24],
--sum([25-44]) as [25-44],
--sum([45-64]) as [45-64],
--sum([65+]) as [65+],
--sum([Not Hispanic or Latino]) as [Not Hispanic or Latino],
```

```
--sum([Hispanics or Latinos]) as [Hispanics or Latinos],
--sum(female) as female,
--sum(male) as male
--from #tempfinal
--WHERE iom in('universal indirect')


--select p.programname, a.*
--from #finalSingle a inner join program p on a.programid = p.programid and a.organizationid =
p.organizationid
--where a.female + a.male > 100 --and a.IOM not like 'Univ%'


drop table #temp1
drop table #temp2
drop table #temp3
drop table #temp4
drop table #temp5
drop table #temp6
drop table #tempPivot
drop table #temp7
drop table #temp7a
drop table #finalrecurring
drop table #finalsingle
drop table #tempfinal



--CBC Code
select sum(a.cnt)
From (select case when numPplReached is null then svcount else numPplReached end cnt
        from cbcreport
        where QuarterID in('057', '058', '061', '062') ) as a
```

Form P13 (Optional)
Number of Persons Served by Type of Intervention

Intervention Type	Number of Persons Served by Individual- or Population-Based Program or Strategy	
	A. Individual-Based Programs and Strategies	B. Population-Based Programs and Strategies
1. Universal Direct	23569	N/A
2. Universal Indirect	N/A	485165
3. Selective	2995	N/A
4. Indicated	21366	N/A
5. Total	47930	485165

Form P14
Number of Evidence-Based Programs and Strategies by Type of Intervention

NOMs Domain: Retention
NOMs Domain: Evidence-Based Programs and Strategies
Measure: Number of Evidence-Based Programs and Strategies

Definition of Evidence-Based Programs and Strategies: The guidance document for the Strategic Prevention Framework State Incentive Grant, Identifying and Selecting Evidence-based Interventions, provides the following definition for evidence-based programs:

- Inclusion in a Federal List or Registry of evidence-based interventions
- Being reported (with positive effects) in a peer-reviewed journal
- Documentation of effectiveness based on the following guidelines:
    - Guideline 1: The intervention is based on a theory of change that is documented in a clear logic or conceptual model; and
    - Guideline 2: The intervention is similar in content and structure to interventions that appear in registries and/or the peer-reviewed literature; and
    - Guideline 3: The intervention is supported by documentation that it has been effectively implemented in the past, and multiple times, in a manner attentive to Identifying and Selecting Evidence-Based Interventions scientific standards of evidence and with results that show a consistent pattern of credible and positive effects; and
    - Guideline 4: The intervention is reviewed and deemed appropriate by a panel of informed prevention experts that includes: well-qualified prevention researchers who are experienced in evaluating prevention interventions similar to those under review; local prevention practitioners; and key community leaders as appropriate, e.g., officials from law enforcement and education sectors or elders within indigenous cultures.

1. Describe the process the State will use to implement the guidelines included in the above definition.
Use of evidence based practices is incorporated into county contract language for prevention services. At least 50% of programs implemented must be evidence based practices on the WestCAPT web site (as per guideline 3). All other programs must adhere to the Principles of Effectiveness (as per guideline 1). Use of evidence based practices is tracked using the KIT Solutions database. Additionally, funds are provided to counties specifically for training in implementing evidence based practices.

2. Describe how the State collected data on the number of programs and strategies. What is the source of the data?
Washington State contracts with KIT Solutions, LLC for web based prevention data collection services. Providers indicate the program(s) they will be implemented and provide information on the number of groups each program is provided to. This report counts the number of groups served.

Number of Evidence-Based Programs and Strategies by Type of Intervention

	A. Universal Direct	B. Universal Indirect	C. Universal Total	D. Selected	E. Indicated	F. Total
1. Number of Evidence-Based Programs and Strategies Funded	726	8	734	252	662	1648
2. Total number of Programs and Strategies Funded	907	319	1226	630	670	2526
3. Percent of Evidence-Based Programs and Strategies	80.04%	2.51%	59.87%	40.00%	98.81%	65.24%

==The following code was used to generate the report ==

/* Block Grant
Form P14: Number of Evidence-Based Programs and Strategies by Type of Intervention
INSTRUCTIONS FROM BGAS as of 8-Sept-2010
For each intervention type listed above, record the following information:
· Row 1: Number of evidence-based programs and strategies. Enter the number of evidence-based programs and strategies:
- Report the number of evidence-based programs and strategies funded by SAPT Block Grant funds. For example, if a State funds 10 providers and each provider implements 3 evidence-based programs and strategies, and each program is implemented 3 times, the State would report “90” as the number of evidence-based programs and strategies.
- Include all evidence-based programs and strategies that were funded wholly or in part by SAPT Block Grant funds during the calendar year. Include the program and strategy even if the SAPT Block Grant funding constituted a minor part of the funding.
For programs and strategies lasting longer than a year or that span the calendar year, include the data for the reporting year only.
· Row 2: Total number of programs and strategies. Enter the total number of programs and strategies:
- Report the number of all programs and strategies funded by SAPT Block Grant funds. For example, if a State funds 10 providers and each provider implement 5 programs and strategies, and each program is implemented 3 times, the State would report “150”as the number of programs and strategies.
- Report the number of all programs and strategies funded wholly or in part by SAPT Block Grant funds during the calendar year. Include evidence-based programs and strategies in the total. Include the program and strategy even if the SAPT Block Grant funding constituted a minor part of the funding.
For programs and strategies lasting longer than a year or that span the calendar years, include the data for the reporting period only.
· Row 3: Percent of evidence-based programs and strategies. Determine this by the following formula:
Percent of evidence-based programs and strategies:
= Number of evidence-based programs and strategies x 100
Total number of programs and strategies

In other words:
Count the number of groups with services in the Calendar Year
*/

```
declare @dtStart datetime
declare @dtEnd datetime
set @dtStart = '20080101'
set @dtEnd = '20081231'

--All groups with services in the date range
```

```
SELECT s.parentorgid as organizationid, s.ProgramID, s.GroupID, p.csapcode, t.ptype as IOM
into #temp1
FROM [Service] s
    inner join program p on s.parentorgid = p.organizationid and s.programid = p.programid
    INNER JOIN indxProgType t on p.ptypeid = t.ptypeid
WHERE (s.SVdate BETWEEN CONVERT(DATETIME, @dtStart, 102) AND CONVERT(DATETIME,
@dtEnd, 102))
GROUP BY s.parentorgid, s.ProgramID, s.GroupID, p.csapcode, t.ptype

select IOM, count(*) as num into #tempNum from #temp1 where csapcode <> '' and csapcode is not
null group by IOM
select IOM, count(*) as den into #tempDen from #temp1 group by IOM

select a.*, b.den,
round(convert(float, a.num) / convert(float, b.den), 2) as pct
from #tempNum a inner join #tempDen b on a.IOM = b.IOM


drop table #temp1
drop table #tempNum
drop table #tempDen
```

Form P15 - FY 2008 Total Number of Evidence Based Programs and Total SAPT BG Dollars Spent on Evidence-Based Programs/Strategies

IOM Categories	FY 2008 Total Number of Evidence-Based Programs/Strategies for each IOM category	FY 2008 Total SAPT Block Grant $Dollars Spent on evidence-based Programs/Strategies
1. Universal Direct	726	$ 2902579
2. Universal Indirect	8	$ 38500
3. Selective	252	$ 698442
4. Indicated	662	$ 5072583
5. Totals	1648	$8,712,104.00

Note: See definitions for types of interventions in the instructions for P-14 (Universal Direct, Universal Indirect, Selective, and Indicated)

Dollar amounts provided in this report are estimated amounts that the providers report into the Prevention MIS (PBPS) prior to program delivery. We do not collect expenditures in the PBPS, nor do providers bill by IOM type.

The following code was used to generate the report.

```
declare @dtStart datetime
declare @dtEnd datetime
set @dtStart = '20080101'
set @dtEnd = '20081231'

--All groups with services in the date range
SELECT s.parentorgid as organizationid, s.ProgramID, s.GroupID, p.csapcode, t.ptype as IOM
into #temp1
FROM [Service] s
    inner join program p on s.parentorgid = p.organizationid and s.programid = p.programid
    INNER JOIN indxProgType t on p.ptypeid = t.ptypeid
WHERE (s.SVdate BETWEEN CONVERT(DATETIME, @dtStart, 102) AND CONVERT(DATETIME,
@dtEnd, 102))
GROUP BY s.parentorgid, s.ProgramID, s.GroupID, p.csapcode, t.ptype

select IOM, count(*) as num into #tempNum from #temp1 where csapcode <> '' and csapcode is not
null group by IOM
select IOM, count(*) as den into #tempDen from #temp1 group by IOM

select a.*, b.den,
round(convert(float, a.num) / convert(float, b.den), 2) as pct
from #tempNum a inner join #tempDen b on a.IOM = b.IOM

--For form P15
--get the funding amount and type for all EBP counted in P14
select distinct a.IOM, a.programid, a.organizationid , p.fdamount, isnull(p.fundingtypeid, 2) as fType
into #tempA
from #temp1 a
    inner join program p on a.programid = p.programid and a.organizationid = p.organizationid
where a.csapcode <> '' and a.csapcode is not null
order by programid

--for those that are funded by-group, get the number of groups.
select a.programid, a.organizationid, s.groups
into #tempB
from #tempA a inner join
    (select s.programid, s.parentorgid, count(s.groupID) as groups
        from [service] s
        where s.SVdate BETWEEN CONVERT(DATETIME, @dtStart, 102) AND
CONVERT(DATETIME, @dtEnd, 102)
        group by s.programid, s.parentorgid) s on a.programid = s.programid and a.organizationid =
```

```
s.parentorgid
where a.ftype = N'1'

--put A and B together. Where it's a per-annual amount, use 1 as the multiplier
select a.*, isnull(b.groups, 1) as multiplier, fdamount * isnull(b.groups, 1) as dollars
into #tempC
from #tempA a
    left outer join #tempB b on a.programid = b.programid and a.organizationid = b.organizationid

--output, estimated dollars by EBP
select IOM, sum(dollars) as total from #tempC group by IOM




drop table #temp1
drop table #tempNum
drop table #tempDen

drop table #tempA
drop table #tempB
drop table #tempC
```

Prevention Corrective Action Plan (submit upon request)

1. Describe the corrective action plan, including critical steps and actions the State and its providers will employ to collect and report the National Outcome Measures data.

2. Discuss the timeframes for the State's corrective action plan detailing the planned milestones and other measures of progress the State has incorporated into its corrective action plan.

3. Describe the State's corrective action plan implementation monitoring activities including interventions or adjustments the State will employ when timeframes or milestones are not achieved.

This narrative response not included because it does not exist or has not yet been submitted.

Approved Substitute Data Submission Form

Substitute data has not been submitted for prevention forms.

Prevention Attachment D

FFY 2008 (Optional Worksheet for Form P-15)–Total Number of Evidence-based Programs/Strategies and the Total FFY 2008 SAPT Block Grant Dollars Spent on Substance Abuse Prevention Worksheet . Note: Total EBPs and Total dollars spent on EBPs may be transferred to Form P-15.

Note: The Sub-totals for each IOM category and the Total FFY 2008 SAPT Block Grant Dollars spent on Evidence-based programs/strategies may be transferred to Form P-15.

See: The instructions for Form P-14 for the Definition, Criteria and Guidance for identifying and selecting Evidence-Based Programs and Strategies.

Form P15 Table 1: Program/Strategy Detail for Computing the Total Number of Evidence-based Programs and Strategies, and for Reporting Total FFY 2008 SAPT Block Grant Funds Spent on Evidence-Based Programs and Strategies.

1	2	3	4
FFY 2008 Program/Strategy Name Universal Direct	**FFY 2008 Total Number of Evidence-based Programs and Strategies by Intervention**	**FFY 2008 Total Costs of Evidence based Programs and Strategies for each IOM Category**	**FFY 2008 Total SAPT Block Grant Funds Spent on Evidence-Based Programs/Strategies**
1.			
2.			
3.			
4.			
Subtotal			
Universal Indirect Programs and Strategies			
1.			
2.			
3.			
4.			
Subtotal			
Selective Programs and Strategies			
1.			
2.			
3.			
4.			
Subtotal			
Indicated Programs and Strategies			

1.			
2.			
3.			
4.			
Subtotal			
Total Number of (EBPs)/Strategies and cost of these EBPs/Strategies	#	$	
Total FFY 2008 SAPT Block Grant Dollars $ Spent on Evidence-Based Programs and Strategies			$

Description of Supplemental Data

States may also wish to provide additional data related to the NOMs. An approved substitution is not required to provide this supplemental data. The data can be included in the Block Grant appendix. When describing the supplemental data, States should provide any relevant Web addresses (URLs) that provide links to specific State data sources. Provide a brief summary of the supplemental data included in the appendix:

This narrative response not included because it does not exist or has not yet been submitted.

Attachment A, Goal 2: Prevention

Answer the following questions about the current year status of policies, procedures, and legislation in your State. Most of the questions are related to Healthy People 2010 (http://www.healthypeople.gov/) objectives. References to these objectives are provided for each application question. To respond, check the appropriate box or enter numbers on the blanks provided. After you have completed your answers, copy the attachment and submit it with your application.

1. Does your State conduct sobriety checkpoints on major and minor thoroughfares on a periodic basis? (HP 26-25)

○ Yes ◉ No ○ Unknown

2. Does your State conduct or fund prevention/education activities aimed at preschool children? (HP 26-9)

◉ Yes ○ No ○ Unknown

3. Does your State Alcohol and drug agency conduct or fund prevention/education activities in every school district aimed at youth grades K-12? (HP 26-9)

SAPT Block Grant	Other State Funds	Drug Free Schools
○ Yes	○ Yes	○ Yes
◉ No	◉ No	◉ No
○ Unknown	○ Unknown	○ Unknown

4. Does your State have laws making it illegal to consume alcoholic beverages on the campuses of State colleges and universities? (HP 26-11)

○ Yes ◉ No ○ Unknown

5. Does your State conduct prevention/education activities aimed at college students that include: (HP 26-11c)

Education Bureau?	○ Yes	○ No	◉ Unknown
Dissemination of materials?	◉ Yes	○ No	○ Unknown
Media campaigns?	○ Yes	◉ No	○ Unknown
Product pricing strategies?	○ Yes	◉ No	○ Unknown
Policy to limit access?	○ Yes	◉ No	○ Unknown

6. Does your State now have laws that provide for administrative suspension or revocation of drivers' licenses for those determined to have been driving under the influence of intoxication? (HP 26-24)

◉ Yes ○ No ○ Unknown

7. Has the State enacted and enforced new policies in the last year to reduce access to

alcoholic beverages by minors such as: (HP 26-11c, 12, 23)

Restrictions at recreational and entertainment events at which youth made up a majority of participants/consumers:	○ ● ○ Yes No Unknown
New product pricing:	○ ● ○ Yes No Unknown
New taxes on alcoholic beverages:	● ○ ○ Yes No Unknown
New laws or enforcement of penalties and license revocation for sale of alcoholic beverages to minors:	○ ● ○ Yes No Unknown
Parental responsibility laws for a child's possession and use of alcoholic beverages:	○ ● ○ Yes No Unknown

8. Does your State provide training and assistance activities for parents regarding alcohol, tobacco, and other drug use by minors?

● Yes ○ No ○ Unknown

9. What is the average age of first use for the following? (HP 26-9 and 27-4) (if available)

	Age 0 - 5	Age 6 - 11	Age 12 - 14	Age 15 - 18
Cigarettes	○	○	○	○
Alcohol	○	○	○	○
Marijuana	○	○	○	○

10. What is your State's present legal alcohol concentration tolerance level for: (HP 26-25)

Motor vehicle drivers age 21 and older? 8
Motor vehicle drivers under age 21? 2

11. How many communities in your State have comprehensive, community-wide coalitions for alcohol and other drug abuse prevention? (HP 26-23)

Communities: 34

12. Has your State enacted statutes to restrict promotion of alcoholic beverages and tobacco that are focused principally on young audiences? (HP 26-11 and 26-16)

● Yes ○ No ○ Unknown

The response is question 9 is for 10th graders, and it is specific to those who had used the substance (that is, it is not the average age for all kids, but rather the average age for all 10th graders who has used the substance at least once).

Appendix A - Additional Supporting Documents (Optional)

Appendix A - Additional Supporting Documents (Optional)

No additional documentation is required to complete your application, besides those referenced in other sections. This area is strictly optional. However, if you wish to add extra documents to support your application, please attach it (them) here. If you have multiple documents, please combine them together in One Word file (or Excel, or other types) and attach here.

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