Washington

UNIFORM APPLICATION
FY 2024/2025 – STATE BEHAVIORAL HEALTH ASSESSMENT AND PLAN

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

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

and

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

ASSESS THE STRENGTHS AND NEEDS OF THE BEHAVIORAL HEALTH SYSTEM

Provide an overview of the state's M/SUD prevention (description of the current prevention system's attention to individuals in need of substance use primary prevention), early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. In general, the overview should reflect the MHBG and SUPTRS BG criteria detailed in "Environmental Factors and Plan" section.

The Washington State Health Care Authority (HCA) is committed to whole-person care, integrating physical health and behavioral health services while also focusing on the social determinants of health for better results and healthier residents.

As of July 1, 2018, the Revised Code of Washington (RCW) Chapter 41.05.018 transferred the powers, duties, and functions of the Department of Social and Health Services pertaining to the behavioral health system and purchasing function of the behavioral health administration, except for oversight and management of state-run mental health institutions and licensing and certification activities, to the Washington State Health Care Authority to the extent necessary to carry out the purposes of chapter 201, Laws of 2018.

On Jan. 1, 2020, the Health Care Authority (HCA) finished a multi-year effort to integrate physical health, mental health and substance use disorder treatment services into one system for nearly 2 million Apple Health (Medicaid) clients. Integration has improved prevention and treatment of behavioral health conditions. Integration, leading to better whole person care, is working to enable many individuals to avoid commitment at the state psychiatric hospitals or divert from jails, and support them in leading healthy, productive lives. Several initiatives have been launched to improve the social determinants of health including two new Medicaid benefits that address homelessness and unemployment.

HCA integrates state and federal-funded services for substance use, mental health and problem gambling. We provide funding, training, and technical assistance to community-based providers for prevention, intervention including harm reduction strategies, treatment, and recovery support services to people in need.
With our community, state, and national partners, we are committed to providing evidence-based, cost-effective services that support the health and well-being of individuals, families, and communities in Washington State.
Our goals are to prevent substance use disorders, educate communities on mental health and support holistic, evidence-based, person-centered care that addresses both medical and behavioral health conditions.

Within HCA, the Division of Behavioral Health and Recovery (DBHR) provides a broad range of community based mental health, substance use disorder, and pathological and problem

gambling services using multiple funding sources to meet the broad behavioral health needs for the citizens of our state. In addition, DBHR sponsors recovery supports and the development of system of care networks. Some of the key services DBHR provides are:

- Substance Use Disorder Prevention
- Early Intervention
- Outreach, engagement, crisis services
- Harm Reduction strategies
- Outpatient substance use disorder and mental health services
- Inpatient/residential substance use disorder and mental health services
- Mental health promotion (funded with GF-State)
- Recovery support services
- Problem gambling services

DBHR manages many funding sources that support public behavioral health services in Washington State. This includes program policy and planning, program implementation and oversight, fiscal and contract management, information technology, and decision support. In addition to these programs, DBHR contracts with the Division of Research and Data Analysis (RDA), within the Department of Social and Health Services (DSHS), to conduct comprehensive research and outcome studies.

Washington State emphasizes data driven decision-making for assessment, care coordination, and
service implementation. In collaboration with DBHR, RDA has developed an innovative web-based
clinical decision support application, Predictive Risk Intelligence System (PRISM). PRISM features state-of-the-art predictive modeling to support care management for individuals with lived experience with
significant health and behavioral health needs. Predictive modeling uses data integration and statistical analysis to identify persons who are at risk of having high future medical expenditures or high likelihood of admission to the hospital within the next year. For instance, PRISM identifies:

- The top 5-7 percent of the Medicaid population who are expected to have the highest medical expenditures for eligibility for health home services.
- Foster youth with complex medical and behavioral health needs.
- Persons with schizophrenia and identifying gaps in their medication which could put them at increased risk of hospitalization.
- Chronic health conditions of clients who are applying for SSI.
- Health services utilization (medical, behavioral health, long-term services and supports, and long-term care) associated diagnoses, pharmacy, and assessments from both Medicaid and
- Medicare sources (for those clients eligible for both).

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

- Integrated physical and behavioral health purchasing through managed care.
- Building on a continuum of services including prevention, intervention, harm reduction treatment, crisis services and recovery support, which incorporate evidence-based programs and practices whenever possible.
- Implementation of a fee-for-service program for American Indian (AI)/Alaskan Natives (AN) for substance use disorder and mental health treatment services.
- Develop cross agency strategies for opiate substitution treatment by securing several federal grants to address the opioid crisis.
- Develop a plan, process, and structure that supports treatment and recovery for individuals who experience a substance use and mental health disorder. Individuals who experience a co-occurring disorder (COD) have one or more substance use related disorders as well as one or more mental health related disorders.
- Implementation of Secure Withdrawal Management and Stabilization Facilities.
- Implementation of two new Medicaid benefits that provide supportive housing and supported employment services to individuals most in need.
- Recovery services including but not limited to client support funds, Recovery Cafes, peer support and housing resources for individuals transitioning from inpatient settings. Supportive Housing and Supported Employment
- Intensive outpatient and partial hospitalization pilot projects
- Working with the Washington office of superintendent of public instruction (OSPI) on Project AWARE grants to behavioral health services in schools.
- Consulting on TRANSFORM (Trauma and Racism Addressed by Navigating Systemic Forms of Oppression using Resilience Methods) a holistic and culturally responsive approach to addressing levels of distress that result from traumatic experiences that includes racism.
- Center of Parent Excellence that supports parents with children and youth experiencing behavioral health with peer support, education, and supportive groups
- Youth Behavioral Health Navigators where regional teams are convening partners across the region to work on issues concerning children youth and family behavioral health, and convening multidisciplinary teams to support individual families accessing and connecting with services
- DBHR collaboratively develop the State Strategic Plan for SUD Prevention and Mental Health Promotion with 25 other state agencies and organizations. This plan captures in detail the needs and resources for Washington's Behavioral Health promotion and prevention services. Plan can be found on the Athena Forum. ~~here: https://theathenaforum.org/prevention-priorities~~
- DBHR funds and supports through technical assistance and training community level strategic planning that includes localized needs and resources assessment in following the Strategic Prevention Framework.
- Creation of the Indian Nation Agreement, honoring tribal sovereignty and government to government principles. This agreement accounts for the ability for the Tribe to utilized federal and grant funds to address needs in their community as they see appropriate and allowable with the parameters of any federal or state purposes. This

also includes using culturally based and tribal based practices within their communities.

DBHR provides prevention, intervention, inpatient treatment, outpatient treatment, crisis services and recovery support to people who are risk for addiction or diagnosed with serious mental illness. In state fiscal year 2022:

- 43,650 clients participated in substance use disorder treatment.
- 12,516 unduplicated participants received direct services through substance use disorder prevention and mental health promotion programs and reached 7,864,400 people through population level campaigns and strategies.
- 1,690 youth received SUD outpatient treatment services.
- 197,364 adults with serious mental illness received outpatient mental health treatment services.
- 885 peers received Certified Peer Counseling (CPC) training through the Peer Support Program compared to 417 in FY20
- 530 Certified Peer Counselors registered for the 2022 Peer Pathways Annual Workforce Development Conference.
- 4,589 enrollments in Supported Employment services in SFY 2022.
- 7,338 enrollments in Supportive Housing services in SFY 2022.
- Twelve coordinated care sites were actively serving youth experiencing first episode psychosis. In SFY 2022 a total of 308 youth were served through these coordinated specialty care sites.
- HCA utilized state funds to build and sustain the workforce by creating a Housing First and Harm Reduction webinar series and a two day, in-person/virtual training sessions scheduled for June 21-22, 2023.
- 1,813 pregnant and parenting women received case management services.
- HCA began or continued Tribal pilots to implement culturally adapted programs such as New Journeys, Wrap Around with Intensive Services (WISe), Contingency Management, and more.

The Block Grants are an important driver to assist Washington State and DBHR to continue moving forward with integration of Behavioral Health and Physical Health Services. Specifically, our plan will address Substance Abuse and Mental Health Services Administration's (SAMHSA) required areas of focus, including:

- Comprehensive community-based services for adults who have serious mental illness, older adults with serious mental illness, children with serious emotional disorder and their families, as well as individuals who have experienced a first episode of psychosis.
- Services for persons with or at risk of substance use and/or mental health disorders with the primary focus on Intravenous drug users and pregnant and parenting women who have a substance use and/or mental health disorder.

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

populations.

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

As we assess the Washington State Behavioral Health System, it is clear the complexity of the system
defies a simple description. In the next few sections, Washington State's behavioral health system is
described as follows:

- Contracting of the state's public behavioral health system
- Adult Behavioral Health system including addressing the opioid epidemic in Washington State
- Children and Youth Behavioral Health System
- Recovery Supports Services
- An overview of the continuum of care offered by Washington State
- Innovative Behavioral Health Strategies in Washington State

Throughout our block grant plan, we incorporate the voices of individuals with lived experience, tribes, and other system partners.

CONTRACTING OF THE PUBLIC BEHAVIORAL HEALTH SYSTEM

Public Behavioral Health System in Washington

Washington State's public behavioral health system consists of two key components: the community behavioral health system and the state psychiatric hospitals. An array of funding streams blends together to fund this entire system, including but not limited to Medicaid; general state funds; federal block grants; local/county sales tax funding; Opioid Settlement Funds, Designated Cannabis Account funds; and a variety of smaller grants from federal government agencies such as the Substance Abuse Mental Health Services Administration (SAMHSA).

Community Behavioral Health System - Overview

In 2018, the state legislature passed 2nd Engrossed Substitute House Bill 1388, transferring the responsibility for administering the public community behavioral health system from the Department of Social and Health Services (DSHS) to the Health Care Authority (HCA). This move consolidated much of the purchasing and administration for Medicaid behavioral and physical healthcare through managed care contracts with an intent to better integrate healthcare. The Division of Behavioral Health and Recovery (DBHR) transferred from DSHS to the HCA, bringing with it additional behavioral health programs, grants, and activities.

Washington completed the transformation process of moving whole-person care, integrating physical and behavioral health in January 2020. With integrated managed care, a managed care plan coordinates and pays for both physical health and behavioral health services. Washington's behavioral health system is divided into ten regions, each region has three or more Managed Care Organizations (MCO).

In addition, each region has a Behavioral Health – Administrative Service Organization (BH-ASO) to cover mental health and substance use disorder crisis services, as well as services (within available funding) for Washington state residents who are not eligible for Medicaid benefits. BH-ASOs collaborate with Medicaid managed care to ensure coordinated care for enrollees. Additionally, BH-ASO's and Tribes, hold the State-only and federal block grant contracts to provide services that are not covered by Medicaid for low-income individuals and Medicaid enrollees. The state also has a robust Indian Health Care Delivery System that includes Indian Health Services (IHS) clinics and 32 Indian Health Care Providers, and several urban Indian organizations. Funding for the Indian Health Care Delivery system, if funded by the funding sources mentioned above, along with dollars from the IHS for those Tribes with compacts from the IHS for self-determination and IHS clinics. The Federal government has directed states to pass through funds to Tribes to meet their federal trust responsibilities to AI/AN individuals to provide health care as a treaty right.

Washington's community behavioral health system offers the full continuum of care, employing strategies to address substance use prevention and mental health promotion, offering effective mental health and substance use disorder treatment (both outpatient and residential/inpatient), and supporting recovery with a full array of recovery services and supports (peer recovery supports, supported housing and employment).

Medicaid without a managed care plan (Fee-For-Services)

Effective July 1, 2017, DBHR established a fee-for-service program for behavioral health services, specifically for individuals that do not chose to opt into managed care or have unique circumstances which do not allow them to participate in managed care. Federal law ensures that AI/AN individuals not required to opt into managed care, and HCA implemented this program to follow this law. American Indians/Alaska Natives receiving Washington Apple Health (Medicaid) coverage have the choice to receive their treatment of mental health and substance use disorder either through the managed care program or through the Apple Health fee-for-service (FFS) program. These individuals now have the freedom of choice of any behavioral

health provider participating in the fee-for-service program and currently accepting patients. There are approximately 300 non-tribal providers, statewide, participating as FFS providers. If AI/AN Apple Health clients are eligible to receive care at an Indian Health Service (IHS) facility, Tribal health program, or urban Indian health program, this change does not affect their ability to receive care at those programs.

During the 2023 legislative session, the State chose to increase the FFS rates by 22% to be at parody with managed care rates. This change is intended to increase access for individuals without a managed care to needed and time sensitive behavioral health services, by building equality in the system.

State Psychiatric Hospitals

Washington has three psychiatric state hospitals: Western State Hospital, Eastern State Hospital, and the Child Study and Treatment Center. The state psychiatric facilities are operated by the Department of Social and Health Services (DSHS). The state psychiatric care system provides the following:

- Inpatient psychiatric care to adults who have been committed through the civil or criminal court system for treatment and/or competency restoration services.
- Mental health treatment services to individuals who are waiting for an evaluation or for whom the courts have ordered an out-of- custody competency evaluation.
- Evidence-based professional psychiatric, medical, habilitative, and transition services within a Recovery Care model.
- Coordination with the Behavioral Health Organizations (BHOs) or Managed Care Organizations (MCOs) to transition clients back into the community.

In addition to the two state hospitals, DSHS operates the Child Study and Treatment Center (CSTC) that provides inpatient psychiatric care and education to children ages 5 to 18 who cannot be served in less restrictive settings in the community due to their complex needs.

Other State Agencies, Tribal Governments, and Key Partners

The full continuum of care and the integration of physical health with behavioral health relies significantly on care coordination and linking with various state agencies, tribal governments, and a variety of key partners. These include but are not limited to:

- Aging and Long-Term Support Administration, Department of Social and Health Services
- Developmental Disabilities Administration, Department of Social and Health Services
- Department of Children, Youth, and Families
- Juvenile Rehabilitation, Department of Social and Health Services
- Department of Health
- Department of Corrections
- Veterans Administration
- Division of Vocational Rehabilitation
- The University of Washington Alcohol and Drug Abuse Institute
- The Office of Superintendent of Public Instruction
- Liquor and Cannabis Board
- Tribal governments and other tribal partners

- Urban Indian Health Programs (UIHP)s and urban Indian organizations

Grant Funded Programs

The Division of Behavioral Health and Recovery (DBHR) is a division within the Washington State Health Care Authority (HCA), designated as the single state authority for mental health and substance use disorder treatment. DBHR includes many grant funded services and program supports for behavioral health prevention/promotion, early intervention, treatment, and recovery support services for individuals with substance use disorder, serious mental illness, serious emotional disturbance, and/or dual diagnoses.
DBHR programs and services include, but are not limited to:

- SUD Prevention
- MH Promotion
- Outreach, engagement
- Harm Reduction
- Outpatient SUD and MH services
- Inpatient/residential SUD and MH services (including voluntary and involuntary community inpatient services in community hospital psychiatric units and freestanding non-hospital evaluation and treatment facilities (E&Ts))
- Recovery support services
- Pathological and problem gambling services
- Offender Re-entry Services
- Crisis response services

SAMHSA Block Grants and other grant programs are important drivers in supporting Washington State in integrating behavioral health and physical health services.

State Tribal Agreements and Contracts with Tribes

In the fall of 2019, the Health Care Authority negotiated the Indian Nation Agreements (INA's) with Tribal governments through a consultation process. The INA is an umbrella agreement that includes the general terms and conditions and allows to include multiple scopes of work for behavioral health service as needed. This INA also includes the program agreement and scope of work for behavioral health services which includes several state and federal funding resources including the Substance Abuse Block Grant. Indian Nations can braid various funding resources to support services that best meet the needs in the Tribal communities along the spectrum of the continuum of behavioral health including mental health promotion (using state funds only), prevention, treatment, intervention, and recovery support services to support a comprehensive approach. As other federal and state resources are made available to Tribal governments, these can be added to the INA using additional scopes of work. As an example, HCA used the INA to add a scope of work to pass through the COVID SABG and MHBG funding resources made available March 2021. This also allows the Tribes the ability to focus funding on efforts that are most needed within their community that considers their needs and resources that is unique to each tribal government.

Since July 1997, DBHR has been able to provide funds to the Federally Recognized Tribes in Washington State to support the delivery of outpatient treatment services by tribal facilities and community-based prevention activities to tribal members. Each tribe receives a base of $57,499 per biennium, the remaining $1.4 million in funding is allocated to the tribes based on a methodology of 30 percent on population and 70 percent are distributed evenly between the tribes. In addition to this amount, the tribes can now access up to $50,000 of state SABG funds to support opioid response efforts. As funding resources become available, the HCA continues to identify if new funding resources can be distributed to Tribes and urban Indian organizations. For example, the HCA set aside 3% of the block grant COVID enhancement funding to provide to Tribes to implement programs through a negotiated plan as needed for their communities.

HCA plans to maintain the current level of regular Block Grant funding for Tribes and identify additional funding resources so that Indian Nations have the resources to expand their behavioral health programs as they feel is necessary for their community. Since 2020, the budget to Tribes within the INA has more than doubled, with now over seven million in funding through various resources, and more are needed.

In addition to funding provided by the DBHR block grant funds, Tribes can also contract with BH-Administrative Services Organizations.

Separate from block grant funding, the Tribes receive Medicaid reimbursement for outpatient services at the IHS encounter rate. This rate is based on tribal costs to deliver services and is negotiated every year between the Indian Health Service and the Centers for Medicare and Medicaid Services. Under 42 U.S.C. § 1396b(w)(6) and 42 C.F.R. § 433.51, the state has required local and tribal governments to provide the non-federal match for all Medicaid reimbursements for outpatient SUD treatment services. For outpatient substance use disorder treatment services provided by tribes to AI/AN clients, the federal portion is 100% - so tribes receive 100% of the IHS encounter rate for these services and there is no non-federal match. For outpatient substance use disorder treatment services provided by tribes to non-AI/AN clients, the tribe receives the federal match percentage appliable to the client (either 50% or 90%) and is responsible for the non-federal match (also known as the tribal match) using the Certified Public Expenditure attestation process. HCA offers technical assistance, training, and consultation to Tribal 638 mental health programs on billing procedures and Medicaid regulations. Additionally, the Tribes have access to 20% of the State Opioid Settlement funds.

The Health Care Authority regularly collaborates with Tribal governments and Tribal and non-Tribal Indian Health care providers on the implementation of statewide initiatives for Tribal members and for AI/AN individuals in WA state. A few examples include:

- Support for various statewide conferences as outlined in the conference and training section.
- Support for the American Indian/Alaska Native Opioid Response Workgroup.
- Support for the Tribal Centric Behavioral Health Advisory Board focused on expanding access to crisis services for AI/AN and better engagement for Tribal governments and

IHCPs in service delivery for crisis and behavioral health services. Specific activities within this project include, implementation of HCA appointed Tribal Designated Crisis Responders, Washington Indian Health Coordination Hub, implementation of the Washington Indian Behavioral Health Improvement Act, ombudsman and care coordination support for complex cases, support to the maintenance of the TCBHAB with the goal of developing a Tribally operated Tribal Evaluation and Treatment facility and/or Secure Withdrawal Management facility for AI/AN individuals, development of Tribal crisis coordination protocols.

- Support for the implementation of the Community Health Aide Program, Alaska model to be implemented in Washington state, and specifically the implementation of Behavioral Health Aides. ~~https://www.npaihb.org/chap-community-health-aide-program/~~
- Support to enhance and provide specific Certified Peer Counseling trainings and support for recovery coaches and recovery support services program, which is a new body of work specifically with Tribal governments.
- Support for Traditional Healing services/Traditional Indian Medicine documentation and outcome measures report.
- Support to establish and updated data reporting system to replace the current system for SUD services called TARGET. This project aims to identify a mechanism that considers how Tribes collect date through the Indian Health Services system RPMS and various Electronic Health Records.
- Support for increase in access to behavioral health surveillance data such as the Healthy Youth Survey.
- Support to develop and adapted training materials for the Wrap Around with Intensive Services Model.
- Development of the Tribal Opioid Solutions Campaign assets, materials, technical assistance for localizations and statewide media buys for AI/AN and Tribal member audiences across the state. The HCA also partners with the Department of Health to connect this campaign to the new Tribal Suicide Prevention Campaign.~~gn. https://watribalopioidsolutions.com/~~
- The HCA maintains any government-to-government plans that have previously been developed with Tribes and urban Indian organizations around the topics of prevention, mental health, and SUD. HCA plans to expand the G2G plans to other health care areas as prioritized by Tribal governments and urban Indian organizations.

Recovery support services are an important part of the continuum of care from prevention to treatment and aftercare. Recovery support services consist of Recovery housing, recovery celebration and community recovery activities which can include: Recovery Coaching, Recovery Housing, and Recovery Care Management and Transition Services, Medication Assisted Treatment/Opiate Substitution Treatment, Purchase and Distribution of Opioid Reversal Medication (Naloxone Kit, Narcan Kit), Treatment Counseling for Non-Medicaid Individuals, Continuing Education/Training (for staff), Engagement and Screening, Recovery House Residential Treatment, Recovery Coaching and Recovery Housing, Public Awareness on Opioid Substitute Treatment (MOUD), adaptation of statewide

Tribal Treatment Media Campaign, media campaign development, Treatment Coordination, and Other opioid recovery strategies.

Primary Prevention Services

The Health Care Authority prioritizes funding for evidence-based and research-based strategies to prevent substance use disorders, while at the same time recognizing the importance of local innovation to develop programs for specific populations and emerging problems, including support for cultural activities as a prevention strategy for tribal and AI/AN communities. Funding for direct services is primarily disseminated via:

- County contracts,
- ESDs,
- School districts/schools,
- Community-based organization contracts.
- Inter-local contracts.
- Indian Nation Agreements (INA) with Washington State Federally Recognized Tribes through the Office of Tribal Affairs (OTA).

HCA uses Interlocal agreements, Vendor contracts and Professional service agreements for services such as public education campaigns, data surveillance, analytics and assessments, workforce development training and capacity building.

HCA has services and activities in all CSAP categories. Most services provided are structured evidence-based SUD prevention curriculum for youth and parenting classes for adults. Information dissemination efforts and alternative drug-free activities are permitted as part of comprehensive strategic program plans. Community and School-based services include problem identification and referral. Services also include community organizing efforts and environmental strategies that impact policy, community norms, access and availability of substances and enforcement of policies directed at substance use disorder prevention. HCA leads and engages in several statewide collaborative efforts that focus on workforce development; planning and data collection about youth and young adults; mental health promotion; and prevention of underage drinking, youth cannabis use, prescription and opioid misuse and abuse.

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

HCA contracts with Educational Service Districts (ESDs) for the placement of Student Assistance Professionals (SAPs) in schools as part of CPWI to provide universal, selective, and indicated

prevention and intervention services using an evidence-based program, Project SUCCESS (Schools using Coordinated Community Efforts to Strengthen Students). Student Assistance Professionals (SAPs) assist students to overcome problems of substance misuse and strive to prevent the misuse of, and addiction to, alcohol and other drugs, including nicotine. The SAPs also provide problem identification and referral strategies through referrals to behavioral health providers and support students in their transition back to school after they receive treatment.

Tribes have the discretion to use currently allocated SABG prevention funds to support school-based prevention and intervention services. Funds support staff time in a middle and/or high school to provide both prevention and intervention services.

HCA has also recently secured a replacement system of the current Management Information System which will support prevention services and captures each subcontractor's prevention plan and monitors their progress and impact. Funds will support enhancements to the reporting system that the current system does not currently capture.

HCA has implemented many meaningful workforce development strategies with the assistance of SABG funds that have been made available to SUD professionals both in the field as well as at HCA. These programs include the Substance Abuse Prevention Specialist Training (SAPST), hosted each year by HCA. HCA partners with numerous agencies to host trainings such as the Prevention Ethics Training, whose hours can be credited towards the Prevention Specialist Certification (CPP) which is validated by the Prevention Specialist Certification Board of Washington. All trainings that are offered to providers and contracts in the field are posted to a site, which is supported through block grant funds and serves as a communication conduct with providers and contractors.

DBHR and the Office of Tribal Affairs work with Tribes and Urban Indian Organizations to provide primary prevention and mental health promotion services that include meaningful engagement in traditional and cultural programs as well as information dissemination strategies. HCA supported the delivery of a Native American SAPTS training for prevention professionals working with tribal and urban Indian communities across the state.

ADULT BEHAVIORAL HEALTH SYSTEM

Mental Health

Since the transition to fully integrated managed care, five managed care organizations (MCOs) contract with the Health Care Authority to provide a complete array of physical and behavioral health services to enrolled individuals with Medicaid. The list of possible services includes brief intervention, crisis services, family treatment, freestanding evaluation and treatment, individual and group treatment, high intensity treatment, medication management and monitoring, peer support, rehabilitation case management, mental health treatment in a residential setting, and

stabilization services. In addition to these services, individuals may also receive the mental health services they formerly received via the MCOs prior to integration, such as those provided by clinicians in private practice or via primary care settings. Indian Health Care Plans also provide these services through MCO and Fee for Service payment models.

The MCOs contract with provider groups and community behavioral health agencies. Individuals may choose which MCO they wish to enroll with, and each region has a minimum of three plans responsible for serving the geographical region.

Each region has one Behavioral Health Administrative Service Organization (BH-ASO) responsible for administering the Involuntary Treatment Act (ITA) and the crisis response system for all people in their service area. Crisis services are available to all residents of the state, without regard to funding or Medicaid eligibility. Tribal governments may also choose a designated crisis responder to perform ITA investigations that can be designated by the HCA.

In most communities, crisis and involuntary services are highly integrated. Crisis services include a 24-hour crisis line and in-person evaluations for those presenting with mental health crises. Crises are to be resolved in the least restrictive manner and should include family and significant others as appropriate and at the request of the individual. Washington will be substantially expanding mobile crisis outreach services including child/youth teams on a statewide basis. Recent legislation passed will improve availability of crisis relief centers, mobile crisis, and community-based crisis intervention services in the state with a goal of response times almost on par with other first responders. Washington is also integrating commercial payors into the crisis system to streamline access and improve availability of crisis services. ITA services include in-person investigation of the need for involuntary inpatient care. A person must meet legal criteria and refused or failed to accept less restrictive alternatives to be involuntarily detained.

Voluntary and involuntary community inpatient services for adults are provided in community hospital psychiatric units and in freestanding Evaluation and Treatment facilities (E&Ts) authorized by the MCOs and BH-ASOs or billed directly to the state for individuals without a managed care plan. In addition to community-based mental health services administered by HCA, DSHS's BHA also operates two state psychiatric hospitals serving adults who are civilly committed under RCW 71.05, committed under RCW 10.77 who are court-ordered criminal defendants needing competency and restoration services, or individuals found by a court to be "not guilty by reason of insanity". Jail and community-based competency evaluations are also offered locally. The Governor has directed that these hospitals are to transition to Centers for Forensic Excellence and that civil commitments shall be treated within community-based settings, community hospitals and Evaluation and Treatment facilities. This transition is underway currently, however additional beds and resources are still required in the community for it to be completed. Hospital liaisons from the MCOs (and BH-ASOs for non-Medicaid populations) assist with to transition individuals back into the community.

Substance Use Disorder Treatment

Managed Care Organizations (MCOs) and Behavioral Health Administrative Service Organizations (BH-ASOs), through contracts with community substance use disorder agencies, provide a
complete array of quality treatment services to youth and adults with substance use disorders. Access to substance use disorder outpatient treatment services is initiated through an assessment at a local outpatient or residential facility. The American Society of Addiction Medicine (ASAM) level of care determines medically necessary services as well as where to provide the services. Treatment plans are based on the results of the assessment, are individualized and designed to maximize the probability of recovery.

Both Managed Care organizations and BH-ASO's contract with provider groups and community substance use disorder agencies. Each BH-ASO and FIMC region serve all Medicaid enrollees within its geographical area except for a portion of the American Indian Alaskan Native (AI/AN) population who have opted out of receiving SUD services through the Managed Care Plans and instead have opted to receive services through the fee-for-service delivery system.

Residential and Outpatient Treatment

Intensive residential and outpatient treatment for substance use disorder includes counseling services, medication, case management, life skills, education around SUD, and, in some cases, co-occurring mental health and SUD treatment. Some patients receive only outpatient or intensive outpatient treatment. Other patients transfer to outpatient treatment after completing intensive residential services. Relapse prevention strategies remain a primary focus of counseling. There are currently three types of residential substance use disorder treatment settings for adults in the state:

- Intensive inpatient treatment provides a concentrated program of individual and group counseling, education, and activities for people with SUD and their families. There are currently 58 intensive inpatient residential providers with a total capacity of 1,893 beds. The BHOs may subcontract for intensive inpatient services. Each patient participating in this level of substance use disorder treatment receives a minimum of 20 hours of treatment services each week.

- Long-term residential treatment provides treatment for the chronically impaired adult with impaired self-maintenance capabilities. There are currently 21 adult long-term residential providers with a total capacity of 505 beds. Each patient participating in this level of substance use disorder treatment receives a minimum of four hours of treatment per week.
- Recovery Houses provide personal care and treatment, with social, vocational, and recreational activities to aid with patient adjustment to abstinence, as well as job training, employment, or other community activities. There are currently five adult recovery house providers with a capacity of 58 beds statewide. Each patient participating in this level of substance use disorder treatment receives a minimum of five hours of treatment services per week.

Persons who Use Drugs (PWUD)

Syringe Services Programs (SSP)

Syringe Services Programs (SSP) are community-based public health programs that provide critical services in non-judgmental environments to people who use drugs. Services include sterile injecting supplies and safe disposal, and access to case management, wound care, overdose reversal medication, healthcare, treatment, and support to address immediate needs. The SSP is an important component of a comprehensive set of programs designed to provide compassionate, holistic support to persons who use drugs, while also reducing the spread of HIV and other infectious disease among people who use drugs, their families and communities.

Syringe services programs (SSPs) are community-based prevention programs that provide critical services in nonjudgmental environments to people who use syringes. Services include:

- Sterile supplies
- Safe syringe disposal (PDF)
- Access to healthcare, treatment, and support.
- Syringe service programs are community-based prevention programs that can provide a range of services, including:
    - Overdose prevention education & naloxone access
    - Access to new syringes and injection equipment
    - Disposal of used syringes
    - Vaccination
    - Screening and linkage to care and treatment for infectious diseases like hepatitis C and HIV
    - Wound care
    - Health education, referrals, and linkage to health care and substance use disorder treatment

SSP's improve health outcomes and prevent disease transmission by shortening the length of time a syringe is in circulation and reducing syringe sharing. They assist in facilitate engagement of people who inject drugs in ongoing services, such as testing for HIV and HCV, linkage to health and social services, overdose education and access to naloxone, and referral to drug treatment programs.

Medications for Opioid Use Disorder

Medications for Opioid Use Disorder (MOUD) is offered throughout Washington State through an expanding network of providers. Treatment modalities include Hub and Spoke (H&S), Opioid Treatment Networks (OTNs), Nurse Care Managers (NCMs), Office Based Opioid Treatment (OBOT) and Opioid Treatment Programs (OTPs).

Hub and Spoke (H&S) networks were started with federal funding (STR grant) and established treatment networks in both urban and rural settings. H&S networks support collaborative, tiered levels of psychosocial and medical care to address opioid use disorder (OUD). The networks provide coordinated care within geographic regions led by a *Hub* agency that is supported by five or more contracted behavioral health treatment, primary care, wrap-around, or referral agencies (*Spokes*).

Opioid Treatment Networks (OTNs), a second-generation H&S, are designed to enhance the capacity of organizations to initiate MOUD and ensure referrals to community providers. They are more flexible than H&S in that spokes can be SUD providers, MH providers, jails, syringe exchange programs, emergency departments, etc. OTNs were designed to meet people "where they are at" in a low barrier setting to help reduce risk of overdose. Current OTNs are located across the state in jails, emergency departments, syringe service programs, shelters, and a fire department. Currently, all OTNs are funded through the SAMHSA SOR grant.

Opioid Treatment Programs (OTPs) use medication assisted treatment (MOUD)—the use of medicines—combined with counseling and behavioral therapies to treat patients with OUD. Three FDA-approved OUD medications can be dispensed from an OTP: methadone, buprenorphine, and naltrexone. All OTPs operate under the oversight of the Substance Abuse and Mental Health Services Administration (SAMHSA) and certification is overseen by WA State Department of Health (DOH).

Withdrawal Management

Withdrawal management (also known Detoxification) services are provided to help people safely withdraw from the physical effects of psychoactive substances. The need for withdrawal management services is determined by a patient assessment using the ASAM criteria. There are three levels of withdrawal management facilities recognized in Washington State. Assessment of severity, medical complications, and specific drug or alcohol withdrawal risk determines the level of service needed:

- Sub-acute Detox can be done on an outpatient basis or can be clinically managed residential facilities that have limited medical coverage. Depending on the substance that was being used and the overall health of the individual helps to determine the correct level of care. Staff and counselors monitor patients, and any treatment medications are self-administered.
- Acute Detox are medically monitored inpatient programs that have medical coverage by nurses and physicians who are on-call 24/7 for consultation. They have "standing orders" and available medications to help with withdrawal symptoms. They are not hospitals but have referral relationships with them.
- Acute Hospital Detox is medically managed intensive inpatient that have medical coverage by registered nurses and nurses with doctors available 24/7. There is full access to medical acute care including the intensive care unit if needed. Doctors, nurses, and counselors work as a part of an interdisciplinary team who medically manage the

care of the patient. This level of care is considered hospital care and is not part of the behavioral health benefits provided through the BHOs or MCOs.

Tuberculosis Screening

Tuberculosis screening, testing and education is provided to individuals receiving SABG funded SUD treatment. The services must include tuberculosis counseling, testing and provide for or refer individuals with tuberculosis for appropriate medical evaluation and treatment. When an individual is denied admission to the tuberculosis program because of the lack of capacity, the provider will refer the individual to another provider of tuberculosis services. The provider must conduct case management activities to ensure the individual receives tuberculosis services.

CHILDREN AND YOUTH BEHAVIORAL HEALTH SYSTEM

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

- Implementation of Wraparound with Intensive Services (WISe) emphasizes a wraparound approach to both high-level and other level need youth cases, adopting the Child and
- Adolescent Needs and Strengths (CANS) assessment tool to evaluate needs and strengths in multiple domains for young people in the WISe program.
- Washington State's First Episode Psychosis Initiative called New Journeys, placing emphasis on early intervention services for individuals experiencing early onset symptoms of schizophrenia.
- Family Peer Partner and Youth Peer Partner development in services and system development.
- System of care guiding principles are:
    - Family driven
    - Individualized, strengths based, and evidence formed
    - Youth guided
    - Culturally and linguistically competent
    - Provided in the least restrictive environment
    - Community based
    - Accessible
    - Collaborative and coordinated across an interagency network

The state has established collaborations with other child and youth serving agencies in the state to address behavioral health needs as evidenced by the Children's Behavioral Health Governance Structure. Washington has implemented Family, Youth, and System Partner Round Tables (FYSPRTs) in each of its 10 regions. These convenings include Tribal representative,

youth and family with lived experience in the children's behavioral health system, and representatives from these six youth-serving state partners: Rehabilitation Administration-Juvenile Rehabilitation (RA), Department of Health (DOH), Department of Children Youth and Families (DCYF), Health Care Authority (HCA), Office of Superintendent of Public Instruction (OSPI), and Developmental Disabilities Administration (DDA).

The state had coordinated cross systems contracts for regional FYSPRTS, Children's Long Term Inpatient Program (CLIP), Wraparound with Intensive Services (WISe), and New Journeys (First Episode Psychosis Program). These collaborations have made it possible to establish partnerships to advance Mobile Response and Stabilization Services and establish a Youth and Adolescent Housing Response Team that convenes 4 state agencies to support multi-system involved youth and young adults experiencing housing instability.

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

Contractors will promote the use of evidence-based medicine, evidence-based practice, research-based practice, and evidence-based health care (collectively "EDPs"). The intention is steadily increasing the percentage of EBPP services for children, youth, and young people across the state.

Monitoring and tracking service utilization, costs, and outcomes for children and youth with mental, substance use, and co-occurring disorders are performed through many different methods. These include:

- Tracking evidence-based practice (EBP) reporting, and multiple input methods for WISe system rollout and CANs progress tracking.
- Following through the payment system (ProviderOne).
- Using performance-based contracting and contract monitoring.
- Monitoring Children's Behavioral Health Measures.

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

Mental Health Services

In effort to increase support for physicians to increase screening for mental health conditions, a Partnership Access Line was implemented through partnership with the University of Washington that provides child physiatrist consultation via phone to medical providers to consult in caring for the children and youth they serve. Based on the success of this resource, a call line has been implemented for parents to call for questions, resources, and support. This

access support line went live in January 2019 and is also in partnership with the University of Washington.

Washington has also implemented a Centralized Assessment of Psychosis Service (CAPS) to increase access to comprehensive psychological testing, including assessment pf psychosis risk states, for Washingtonians presenting with early signs of and symptoms of psychosis. This supports individuals in identifying and connecting to the appropriate individualized treatment.

Treatment

In addition to traditional residential and outpatient services, work continues to pilot identification and treatment through partnerships with local juvenile justice, Educational School Districts, Office of Public School Instruction, and the Office of Homeless Youth in the Department of Commerce.

Mental Health Assessment for Young Children

Within the child and youth population in Washington state, young children (birth – age 5) have the highest rates of unmet mental health care needs (HCA, 2022). Research suggests that challenges around reimbursement systems and specialty training are key barriers to access (Perigee Fund, 2021).

In SFY22-23, Washington engaged in several efforts to improve access to care for young children and their families, through specific work around developmentally appropriate mental health assessment and diagnosis, including:

- Revised reimbursement policies to adequately fund assessments best practices, including assessments that take multiple sessions and/or take place in home and community settings (i.e., natural environments). An evaluation of the impact of these reimbursement changes on service delivery will be conducted in SFY24-25.
- Free training in the DC:0-5, the developmentally appropriate diagnostic manual for young children's mental health, which is recommended by both CMS and SAMHSA. Training will continue through SFY24-25.
- Additional tools and resources to support the use of the DC:0-5, including a community-informed DC:0-5 crosswalk, and updated administrative code to allow the use of the DC:0-5 in individual service records. Additional tools and resources will be developed through SFY24-25.

Washington's innovations in this area have been featured in several national publications and conferences, but we know there is still more work to do. Our recent report highlighted the positive impacts of these policy changes, but also areas where challenges remain. In SFY24-25, we will conduct Listening Sessions with providers from each region of the state to better understand challenges and needs, which will inform our ongoing work in this area.

AN OVERVIEW OF THE CONTINUUM OF CARE

DBHR includes services and program support for behavioral health, prevention/promotion, and early
intervention, outreach/engagement, harm reduction, crisis services, treatment, and recovery support services for individuals with substance use disorder,
serious mental illness, serious emotional disturbance, and/or dual diagnoses.

Prevention/Mental Health Promotion

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

Intervention

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

Mental Health Treatment

DBHR funds the behavioral health care plans to provide an integrated public mental health treatment system for persons experiencing mental illness who are enrolled in Medicaid and meet the statutory need definitions for those experiencing a mental health crisis and for those who are deemed a danger to themselves or others due to a mental disorder. To meet the medical necessity criteria, a person must have a diagnosis and the requested service is reasonably expected to improve, stabilize, or prevent deterioration of functioning resulting from the presence of a mental
illness.

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

Crisis Services

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

DBHR awarded the Seattle Crisis Clinic a performance-based contract to operate a behavioral

health recovery helpline. The Washington Recovery Helpline offers 24-hour emotional support and referrals to local treatment services for residents with substance use, problem gambling, and mental health disorders. The Crisis Clinic also operates Teen Link, a teen-answered help line, each evening.

When it appears that an individual meets criterion for involuntary treatment due to a mental health disorder they are referred to a Designated Mental Health Professional, if it appears that they meet criteria for involuntary treatment due to a substance use disorder they can be referred to a Designated Chemical Dependency Specialist, for evaluation (depending on the level of acuity of the individual, and the resources available in their region). If the Designated Mental Health Professional determines that the individual meets criteria for detention under RCW 71.05, they complete a petition for detention and cause the individual to be detained to a certified involuntary psychiatric facility. If the Designated Chemical Dependency Specialist determines that the individual meets criteria for commitment under RCW 70.96A, they complete a petition for commitment and file it with court, which will issue an order for involuntary treatment in a certified substance use treatment facility.

Effective April 1, 2018, Designated Mental Health Professionals became Designated Crisis Responders and have the authority to detain individuals due to mental health disorder or a substance use disorder under RCW 71.05. Individuals detained due to a substance use disorder will be detained to a secure detoxification facility.

If an AI/AN who is served by a tribal behavioral health provider is in crisis, DBHR requires that the BH-ASOs coordinate with the tribal behavioral health provider to provide continuing services during and after the crisis. This is contingent upon the AI/AN client signing a release of information. Tribal governments are working diligently to expand and enhance their crisis services within their communities. This includes crisis response teams, tribal designated crisis responders, and tribal codes for involuntary treatment.

Substance Use Disorder (SUD) Treatment

Substance use disorder, co-occurring assessments use the American Society of Addiction Medicine (ASAM) criteria to help determine and match the individual to the appropriate level of care, and services that meet their needs. Depending upon medical necessity and individual need, outpatient, residential, or withdrawal management and stabilization can be the first entry point when receiving behavioral health services. All SUD, co-occurring providers are licensed and certified treatment agencies by the Department of Health (DOH), whether services are provided to individuals in their local community or in another region. If an individual meets criterion for residential substance use disorder, co-occurring treatment, a referral is made, and the clinician will help assist the individual in the process of being admitted to a residential treatment facility within the state. DBHR is a recipient of The Healthy Transitions Project and System of Care Expansion grants. The Healthy Transitions Project is designed to improve emotional and behavioral health functioning for transition-age youth (TAY) age 16-25. The individual must reside within the catchment area and have been diagnosed with serious emotional disturbance (SED) or serious mental illness (SMI) including those experiencing a co-

occurring disorder. This program aims to develop non-traditional recovery support services and engage TAY that might otherwise not access services. The System of Care Expansion grant provides day support services, therapeutic foster care services, support to expand youth and family networks, and to provide social marketing for mental health promotion with identified key partners.

Family SUD Navigators

The substance use disorder (SUD) family navigator project focuses on implementing navigators statewide who can serve families and individuals of loved ones experiencing SUD, of all ages, to include training, certification, licensed supervision, and development of expertise in serving family members of youth and young adults with SUD in a community-based setting. This work included the development of curriculum to educate SUD family navigators and family members on impacts of substances on the brain, potential responses, and other information to support system navigation and family wellness. DBHR has partnered with a parent run organization to provide these trainings. Each is trained by a family member with lived experience with the support of a clinician.

Collegiate Recovery Program

Block grant funding is used to develop Collegiate Recovery Support services statewide, for a Harm Reduction Approach that combines training on best practices, technical and program development assistance for individual's Institution of Higher Education (IHEs), development of campus/community recovery capital, and facilitated network development to advance skills, share resources, and build sustainable connections. The goal of Collegiate Recovery Support is to offer the chance for students in recovery from substance use to experience the opportunities that higher education offers both in the college environment, and after by providing support, preventing a return to substance use, and promoting successful academic performance. Funding supports a network of programs that include technical and community colleges, private institutions, and 4-year universities. IHEs can receive technical assistance and tailor services to the needs of their specific institution.

Pregnant Individuals and Individuals with Children

Pregnant and Parenting Individuals (PPI) is a priority population. The services for this population are designed to meet the needs of pregnant and parenting women who are seeking services. These services include PPI Substance Use Disorder Outpatient Treatment Services, PPI Substance Use Disorder Residential Treatment Services, PPI Housing Support Services, Therapeutic Intervention for Children, parenting education and family support services with Parent Trust for Washington Children, intensive case management services with the Parent-Child Assistance Program (PCAP), and the Washington State Fetal Alcohol Syndrome Diagnostic and Prevention Network (WA FASDPN).

Pregnant and Parenting Individuals with Children

A 16-bed Substance Use Disorder Residential Treatment Facility in Grays Harbor County, Washington implementing a Family Preservation Model will serve Pregnant, Parenting, and

Partnered Parents. Children will reside in the facility with their parent(s) while their parent(s) receive treatment services.

The integrated model of care will include therapeutic interventions to treat the whole family system. Care coordination along the treatment continuum will include certified peer counselors, case management, and transitional housing support.

The model offers educational opportunities in parenting, counseling, and an onsite licensed childcare center. The model is designed to treat diverse family systems providing culturally attuned, trauma informed services. The model provides pathways for infant and parent dyads to transition into treatment upon safe hospital discharge after birth, when an indication for Substance Use Disorder Treatment, is identified. The model provides strategic partnership the Department of Children, Youth, and Families (DCYF) both State and Tribal Liaison, for safety planning and reunification support, for child-welfare involved caregivers.

Pathological and Problem Gambling

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

Office of Recovery Partnership

The Office of Consumer Partnership (OCP) changed its name in 2020 to the Office of Recovery Partnership (ORP) to better reflect the specific purpose of this office. The office currently consists of one full time staff member. The ORP is a priority within HCA with a clearly defined purpose. Some key elements include:

- Advocates for the inclusion of behavioral health community voice and choice at every level of state government.
- Advocating on behalf of those who have lived/living experience with or who have been impacted by behavioral health challenges.
- Serves as a conduit for those who have lived/living experience with or who have been impacted by behavioral health challenges to work collectively to shape, inform and transform behavioral health systems in Washington State.
- Facilitates ORP Steering Committee comprised of lived/living experienced members from all regions of Washington state representing individuals, families, caregivers, providers, local and state government.
- Facilitates agency wide recovery and wellness employee resource group that provides support, education and resources for agency staff.

- Provides statewide behavioral health education, resourcing, advocacy and leadership training across lifespan.
- Provides oversite for statewide behavioral health lived/living experienced speaker bureau.
- Assists in the development and support of emerging community leadership.
- Promotes wellness and recovery values agency and statewide.
- Provides community outreach and engagement opportunities agency and statewide.
- Engages in the legislative process by providing guidance and review of legislation that effect behavioral health communities.

WORKFORCE DEVELOPMENT

Tribal Behavioral Health Conferences, Workforce Development and Trainings

HCA provides support to several tribal and AI/AN specific trainings and conferences. In the past biennium, HCA has offered financial support for the following conferences and trainings.

- Wrap-Around with Intensive Services (WISe) curriculum training adaptation for Tribal communities – 2023. Technical assistance to support the first Tribal WISe program coming online summer, 2023.
- Training for all new Designated Crisis Responders (DCRs) attending the DCR Academy and Trueblood program implementation staff on government-to-government principle's, the Indian health care delivery system, and best practices for working with Tribes and AI/AN communities, 2022 & 2023.
- Tribal Certified Peer Counselor trainings (2)2023.
- CPC curriculum and testing materials review for cultural attunement and provide recommendations, crosswalk, of WA State CPC curriculum compared to others including culturally based peer training curriculums, using a tribal lense.
- Contracted with WSU to provide technical assistance and work in collaboration with Tribes to develop a culturally adapted:
    - First Episode Psychosis - considerations and materials, building off of the New Journeys model.
    - Contingency Management Program for all substance use disorders, building off of promising outcomes published by WSU.
- Support for a State and Tribal delegation to learn more about the prevention program, Planet Youth Icelandic model to identify best practices that can be implemented in Tribal communities. 2023
- Support for a Tribal-State Opioid/Fentanyl Summit to convene tribal leaders and state elected officials to create solutions to address the fentanyl crisis for AI/AN individuals, families, and communities, convened on May 22-23, 2023.
- Creating of training materials that the Indian Behavioral Health Hub will use to train all 988 crisis line staff and behavioral health aides on the VOA IBHH and Native and Strong

Lifeline (Tribal 988) resources and best practices to working with Tribal communities. Creation of training materials for IBHH staff and families on the Joel's Law petitions.
- Training on the prevention management information system, Minerva, 2023.

HCA is partnering with Tribes, the Northwest Portland Area Indian Health Board, Indian Health Services, and the American Indian Health Commission to work on realizing a new provider type to Washington State, called the Behavioral Health Aides. Behavioral Health Aides are federally licensed by the Indian Health Services and can provide a variety of services including mental health and SUD treatment services, prevention, and crisis response support under the supervision of a licensed clinical professional. The HCA is looking to explore ways that BHA services can be fully funded by various funding streams such as by grants and Medicaid billing. In 2022 and 2023, HCA has been working with these partners to create a State Plan Amendment to incorporate BHAs in the Medicaid State Plan. Tribal Consultation was held, early 2023 and discussion on final language is ongoing. We anticipate this will be submitted to CMS in 2023.

Co-Occurring Disorder Conference

The annual Washington State Co-Occurring Disorder (COD) and Treatment Conference for 2022 was a hybrid event, held on October 10th and 11th. A total of 446 individuals attended the event (270 registered for the virtual track and 176 registered for the in-person track).

The 2022 conference provided attendees (including consumer and family) with information regarding current legislation related to behavioral health care and services, current resources, new and emerging trends, diversity, equity and inclusion, treatment methodologies, burnout and self-care, and peer support. There were three preconference trainings: law and ethics, suicide prevention, and advanced clinical supervision skills.

The 2023 conference is scheduled for October 16th and 17th and will be an in-person event. This will be the first fully in-person COD Conference since 2019. The theme of the 2023 COD Conference is "Stronger Together" and aims to focus on reconnection and community after a long period of remote work and virtual conference experiences. The COD conference will have 4 plenary speakers focused on topics such as vicarious trauma and self-care, stories of hope and inspiration related to behavioral health challenges, diversity, equity and inclusion, and new and emerging trends in the behavioral health field. In addition to the plenary focus areas, the conference will have workshops addressing, Trauma, Medication Assisted Therapies, youth and gender issues, special populations, peer support, new facility types, and leadership and process improvement. The conference also provides opportunities for participants to network with other service providers, state representatives, other families, and individuals with COD.

Behavioral Health Conference

The Behavioral Health Conference is a two-day statewide behavioral health care conference with some all-day preconference workshops presented by the Washington Council for Behavioral Health (WCBH) and supported by the federal block grant.

The 2022 Conference theme was “Surviving and Thriving in a Changing World” and was held virtually June 15-17, 2022. A total of 590 participants registered for the conference; this number includes 73 consumers and consumer/advocates who received registration scholarships. The conference consisted of 35 workshops, as well as four keynote addresses by national speakers. In addition, a pre-conference training session entitled Washington State Law & Ethics for Behavioral Health Professionals was held virtually, in two separate sessions, on Monday, June 6 and Tuesday, June 7. Among the workshop offerings at the WBHC, there were tracks on Corrections & Mental Health, Recovery & Resiliency, Housing & Housing Support Services, Emerging, Best & Promising Practices, Race & Equity in Behavioral Health, and two general Services & Partnerships tracks.

The 2023 Conference theme was “Reconnect and Recharge!” and was an in-person event held June 14-16, 2023, in Kennewick, Washington. This was the first in person Behavioral Health Conference since 2019. The event highlighted 35 workshops, with tracks focusing on recovery & resiliency, race and equity in behavioral health, children, youth & families, corrections & mental health, services and partnerships, and more. The 2023 WBHC keynote speakers were:

- Nii Addy, PhD, a neuroscientist, Yale professor, and mental health advocate, who addressed racial disparities in mental health
- Maia Szalavitz, an expert on harm reduction with personal experience in this area
- Nathaniel Morris, MD, a psychiatrist with expertise on mass incarceration and mental illness

Say~~ing~~ It Out Loud Conference

The Say It Out Loud (SIOL) Conference is planned in partnership with Two-Spirit, Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual (2SLGBTQIA+) communities, experts in the behavioral health field, as well as other state agencies including Aging and Long-Term Support Administration (ALTSA), Dept. of Children, Youth and Families (DCYF), Juvenile Rehabilitation (JR) etc. This conference brings together professionals from diverse fields of human services, mental health, substance use disorder treatment, substance abuse prevention, physical healthcare etc. as well as young people, parents and caregivers. Participants network, gain skills and education to improve the health and well-being of 2SLGBTQIA+ individuals, families and communities. The Division of Behavioral Health and Recovery (DBHR), Health Care Authority (HCA) has a long-standing record and recognizes the importance of partnering with communities, community providers, and state agencies to better support and care for 2SLGBTQIA+ individuals.

The 22nd annual SIOL conference was held Monday May 22, 2023, at the Davenport Grand in Spokane, WA. There were approximately 365 participants from around the state of Washington. The theme was “Let’s Get Reel: Showcasing the realities and experiences of 2SLGBTQIA+ individuals from a personal perspective as well as addressing needs and inequities through effective approaches and whole person care. Let's not shy away from topics, rather elevate them to promote change.” The Keynote, Roo Ramos (they/them) is an Iñupiaq, Two Spirit liberation and equity consultant and nonprofit leader with over 20 years' experience in the nonprofit sector and in advocacy, activism, and systems change work. Roo spent much of

their career advocating for Indigenous children, youth, and families in the school, justice, healthcare, and foster care system.

Each year, experts share the latest research, best practices and information with conference attendees, having one mission, and that is to improve behavioral health services, and whole person care. Workshops offered this year focused on youth, adults and older adults with topics including but not limited to: Keeping It "Reel": Media Impact Campaigns For LGBTQ+ Health Initiatives, LGBTQ+ older adults: Who will help care for us without judgment? Harm Reduction 101: Drugs and How to be Safe, Supporting LGBTQIA+ Young People in Systems of Care. We also have the privilege of providing naloxone in each participant bag. We will be providing a naloxone administration demonstration for all attendees. We want to reduce stigma and normalize carrying naloxone.

Community providers and agencies throughout the state will also attend as exhibitors to share information and resources.

Prevention Summit and Youth Forum

The annual Washington State Prevention Summit (Summit) is an enriching training and networking opportunity for youth, volunteers, and professionals engaged in health promotion and the prevention of substance misuse, violence, and other high-risk behaviors, in a setting that promotes cultural humility. The Summit provides high-quality workshops, forums, and hands-on learning opportunities designed to meet a variety of needs, including professional development for prevention professionals. Specifically, the Summit provides education and training to prevent alcohol, tobacco, cannabis, and opioid misuse. The goals of the Summit are to increase knowledge of prevention science and practice, raise awareness of state issues, and promote the need for continued prevention work by professionals and youth. The Summit also features a track tailored to youth in ages 12 through 18. The youth track gives youth volunteers their own space to increase skills in self-development, peer relationships, drug refusal skills and strategies to strengthen personal commitment against substance use, share experiences, network, and gain knowledge to be effective leaders, prevention advocates and explore how they can be catalysts for meaningful community-level change.

HCA hosted the 2022 Prevention Summit virtually on November 9 and 10 with the theme of “Advancing Prevention: Connection and Hope”. This year we had brought the youth track back and this brought in a total of 138 youth attendees. Alongside the youth, there were a total of 372 adult attendees. In 2022, we were able to host six (6) keynotes, two (2) specifically for youth, two (2) specifically for adults and two (2) specifically for both adults and youth. For the youth track, Nigel Wrangham hosted a keynote on the Strategic Prevention Framework and how youth can apply it to their projects in their communities and Albert Gay shared with youth the foundations of Prevention and empowering youth that when learning Prevention, they are creating a path to healthy living. In addition, we hosted youth workshops around how youth can address stress and learn healthy coping skills and the potential cross risks between gaming and substance use and how youth can build healthy gaming habits that can also lead to overall healthy habits. On the adult track, we invited Dr. Alfgier Kristjansson to share with us his work

and the foundation of the Icelandic Prevention Model and brought in Dr. Jonathan Caulkins to share with us the Cannabis market trends and what we as Preventionists can prepare to do to respond to the ever-changing market. This year, we also had the privilege of working with SAMHSA's Center of Substance Abuse Prevention (CSAP) to invite both the outgoing CSAP Director, CAPT. Jeffrey Coady and incoming CSAP director, CAPT. Jennifer Fan, to host an Adult Power Session. Both CAPT. Coady and CAPT. Fan were able to speak to the CSAP's initiatives to the current challenges we are facing in the behavioral health field today and engage in an engaging Q&A session with our attendees.

We are currently planning for the 2023 Prevention Summit to take place on October 24 and 25 in Spokane, Washington. Currently, we are exploring the idea of hybrid, therefore allowing for folks to join in-person but also have some capability of virtual. We have been convening our planning committee since February 2023 and most of our planning has been around finalizing our theme and graphic. We have been working with our team's internal Graphic Designer to create a graphic to match our finalized theme of "Leading Prevention Together". As we continue to meet with our Planning Committee, we will begin planning around how our agenda will be for the next year along with beginning our Speaker Proposal process to begin submissions for interested speakers.

The Spring Youth Forum is a follow-up conference to the Prevention Summit. The Forum provides youth prevention teams the opportunity to learn from others while showcasing their own education and planning skills. Youth Teams share successes and lessons learned from projects commenced during or following the previous Prevention Summits or other youth trainings. The Prevention Summit and the Spring Youth Forum work in tandem to create momentum and help to encourage, reward and support youth-led prevention work in communities throughout Washington.

After being virtual since 2020, this year's Spring Youth Forum returned to in-person with approximately 300 participants in attendance and marking the 15th anniversary of the conference. The Forum took place on May 10, 2023, at the Great Wolf Lodge Conference Center in Grand Mound, Washington. This year's Forum awarded 40 youth team scholarships to youth leaders across the state who implemented prevention projects. As part of our programming, we hosted a showcase of Youth Prevention Projects, a Youth Town Hall, a keynote presentation on the topic of prescription misuse and opioid prevention and five (5) 60-minute youth development workshops. The youth development workshops covered topic areas related to underage drinking & cannabis prevention, mental health promotion, impaired driving, youth problem gambling prevention and youth leadership development. We have also introduced an Adult-only workshop around engaging youth in prevention efforts using best practices.

Peer Support Training

Increase Peer Workforce

Since 2005, Washington State's Peer Support Program has been training individuals with lived experience in mental health recovery to become Certified Peer Counselors (CPCs). In 2019, in addition to training peers with mental health recovery, the Peer Support Program began training people who solely identify as having lived experience with substance use recovery as peer services were added to the substance use disorder treatment (SUD) section of the state plan. Besides the core duties of training and certifying peer counselors, the program also provides continuing education to certified peer counselors, holds an annual workforce development conference, and provides technical support for agencies who currently have peer programs or want to start a peer program.

Peer support is provided in every region of the state. What started as a small program managed by one person, has now developed into a robust training program with four full time staff. The growth of the program continues to require us to be strategic about the training and certification program. The Peer Support Program has developed a database for peer support training including an online application. This database has allowed us to increase our efficiency and better serve the behavioral health workforce needs. We are now working to expand our data collection from the database to a visual dashboard to measure trends in applications, demographics of peers and training outcomes. This dashboard will allow the Peer Support Team and HCA leadership access to real-time data to anticipate future training needs and increase communication to external stakeholders.

The peer support program is invested in growing a cadre of approved Certified Peer Counselor trainers and approved training organizations in Washington State. The Peer Support Program has created a process utilizing a mentoring toolkit. The toolkit includes core competencies for training and a system for coaching CPCs with two years' experience providing direct peer services to become CPC training mentees. The mentees are mentored and vetted by experienced CPC trainers. The Peer Support Program continues to provide quarterly Train the Trainer events to ensure that Washington's CPC trainers have the skills they need to provide high quality trainings. The Peer Support Program is in process of creating fidelity tools for both CPC Trainings as well as CPC programs.

Since 2005, the Peer Support Program has certified 7,134 Certified Peer Counselors. The Peer support program has 95 trainings scheduled and anticipates training a total of 1,250 CPCs in SFY 2023. In FY22, 885 people were trained as Certified Peer Counselors. Of the 970 trained so far in SFY23, 529 identify as either having substance use or co-occurring recovery have become Certified Peer Counselors. HCA anticipates using a combination of block grant and state dollars to fund a minimum of 90 trainings in SFY24.

With the passing of SSB5555 Certified Peer Specialists, HCA will be enhancing the current 40-hour curriculum to 80 hours. This work will involve collaboration with the Peer Support Advisory Group, providers, and individuals with lived experience to ensure a robust curriculum that is peer centered. This new curriculum will be in line with the new National Model

Standards for Peer Support Certification. HCA has also been tasked to create a supervisor training for certified peer counselors and will begin that work in FY24. This new legislation creates a standalone licensure for Peer Specialists through the Department of Health, currently peer specialists are credentialed under the umbrella of agency affiliated counselors. This new licensure will create three different levels, a peer specialist trainee, a certified peer specialist, and a peer specialist supervisor.

Peer Support Advisory Group

DBHR values the expertise of individuals with lived experience to provide input on the future of the Peer Support Program. The Peer Support Advisory group is comprised of a diverse group of people with lived experience who have knowledge of Certified Peer Counselor training and testing, curriculum development, and who are leaders in the peer community. This group meets on a regular basis to provide feedback on program guidelines, curriculum development, trainer development, and training and testing needs.

Update Curriculum and Training

In 2019, "The Bridge" training was created to certify peers who have been trained in the CCAR Recovery Coach Model in order to meet CMS requirements for the peer services under the Medicaid State Plan. This training allows people who are currently recovery coaches to utilize their knowledge gained in the CCAR training to take a shortened version of the CPC training, it bridges the gap. This training is a shortened version of the standard curriculum that addresses the components that are not covered in the CCAR training. These topics include documentation, ethics, boundaries, sharing your story as a peer counselor, and includes the appropriate skills checks. HCA currently sponsors this training at a minimum of four times a year. HCA is in process of updating the Certified Peer Counselor Standard training curriculum to make it more culturally diverse. These updates are done in collaboration with the Peer Support Advisory Group.

HCA is partnering with Tribes, the Northwest Portland Area Indian Health Board, Indian Health Services, and the American Indian Health Commission to work on realizing a new provider type to Washington State, called the Behavioral Health Aides. Behavioral Health Aides are federally licensed by the Indian Health Services and can provide a variety of services including mental health and SUD treatment services, prevention, and crisis response support under the supervision of a licensed clinical professional.

The Peer Support Program continues to provide continuing education opportunities for Certified Peer Counselors. HCA has the following continuing education trainings available to all CPCs made available online: The Power of Peer Support in Crisis Services, The Intersection of Behavioral Health and the Law, Enhancing Your Cultural Intelligence, An Orientation to WRAP, Certified Peer Counselor Pre-requisite training, Documenting Peer Support, Ethics and Boundaries in Peer Services, The Role Employment Plays in Recovery, and the Role Housing Plays in Recovery. HCA is in process of creating an online LMS training on Mental Health Advanced Directives and will be added to the HCA Peer Support Program website fall of 2023.

Through legislative direction in 2021, HCA developed a 40-hour in person Crisis Training for Certified Peer Counselors who work in crisis settings. This training will be required for all CPCs who work in crisis services. HCA piloted two trainings and has trained a diverse cadre of trainers to facilitate these trainings. The training will be made available to all CPCs beginning July 1, 2023, with priority given to CPCs who work in crisis settings.

In addition to the online trainings, HCA utilized COVID enhancement funds to bolster the peer workforce by providing in person continuing education opportunities. Those trainings included Intentional Peer Support and Wellness Coach Trainings.

Technical Assistance to Agencies

A technical assistance program was created called Operationalizing Peer Support (OPS). OPS provides evidence based technical and professional assistance to agencies with the implementation and operationalization of new and existing peer services. The program supports agencies and organizations through trainings, monthly webinars, and weekly "Office Hours." Training topics include; Peer Services in Washinton state, training and credentialling, creating a recovery orientated and trauma informed environment, licensing as a behavioral health agency and Medicaid reimbursement, recruitment, onboarding, retention of peers. peer oriented supervision, documentation, and ethics and boundaries. Operationalizing Peer Support is funded through both MHBG and SABG and is offered at no cost to agencies.

Additional Workforce Continuing Education and Technical Assistance

In 2023, DBHR held the 7th Annual Peer Pathways Workforce Development Conference. Due to COVID-19 the conference continued in virtual format and was a great success. There were 530 people who registered for the conference. We are currently planning the 8th Annual Peer Pathways Conference that will be held in person as the public health emergency has ended. Conference presenters include National and Local Peer experts with lived experience in Mental Health and Substance Use Recovery. The conference continues to grow, and we are expecting even a larger number of peers to register this year.

In 2021, the Office of Tribal Affairs in partnership with the Peer Support program provided technical assistance for tribes to become approved training entities. In addition to the technical assistance, funding was also used to provide two tribal specific trainings and two tribal specific train the trainer events through September of 2021. These events were and will continue to be used to support tribes in becoming approved training entities. HCA is partnering with the Office of Tribal Affairs to in efforts to adapt the current standard CPC curriculum to better meet the needs of Tribal and Urban Indian individuals and organizations.

COVID-19 Response

When COVID-19 physical distancing requirements were put into place in March of 2020, the Peer Support Program in partnership with our contracted training and testing organizations were able to transition our 40-hour in person training/testing to an interactive virtual training/testing within six weeks. This quick transition helped to keep our certification program on track to meet the needs of the community.

COVID-19 has challenged DBHR, our contracted trainers/testing organizations, and our other approved training organizations to be flexible. This has been a period of growth allowing us to see the value of virtual trainings. Although, in person trainings have been our training gold standard, virtual trainings have made it possible for people in rural and frontier areas, people with childcare needs, and those who are currently working to become certified peer counselors.

DBHR has transitioned back to in person trainings for the bulk of our events, however DBHR continues to offer our certification trainings in a virtual format throughout the year. This allows for individuals who live in rural or frontier areas or have personal or professional commitments that limit their ability to attend in person trainings, access to become a Certified Peer Counselor.

INNOVATIVE BEHAVIORAL HEALTH STRATEGIES IN WASHINGTON STATE

Addressing the Opioid Crisis

The Governor published an Executive Order in October 2016 to take steps to address the opioid crisis. The state developed guidelines to help health care providers treat pain and launch a Statewide Opioid Plan. In addition, the state has secured new SAMHSA grants to assist with these efforts:

Opioid Settlement Funds

Washington State is currently receiving opioid settlement funds from a variety of opioid settlements. Each of these settlements have payment structures that include distributions to the state and to local governments. Some of these settlements will pay out over 17 years or more. The Washington State Legislature retains appropriation authority over state opioid settlement dollars. Local opioid settlement dollars are managed by individual local governments in large population areas, and by groups of local governments in rural areas that have joined together. All local governments are required to report on their use of funds through locally organized Opioid Abatement Councils.

Washington State identified the State Opioid and Overdose Response Plan as the collaborative framework where consensus recommendations on the use of opioid settlement dollars would be developed and submitted for consideration by the Governor's Office.

During the 2023 Regular Session and the 2023 Special Session, the Legislature appropriated over $80 million dollars of opioid settlement dollars for the 2023-2025 biennium. These uses include activities across the continuum including prevention, treatment, recovery support services, harm reduction services and drug user health. Following a formal consultation with Tribes, approximately $15.5 million dollars was distributed directly to Tribes for uses as decided upon themselves.

The Health Care Authority, Department of Health, and other state agencies that lead on the State Opioid and Overdose Response Plan have taken note of lessons learned during the cycle of recommendation development for the use of opioid settlement funds. The State Opioid and Overdose Response Plan will be updated during the next biennium to include those lessons learned; to adjust the plan such that it can be more effective in driving opioid related health care policy; separate out an annually updated workplan that describes funding for opioid related activities; development of a SOORP performance report that includes opioid related public health surveillance data and information on outcomes related to opioid expenditures; and a plan for community engagements, in particular engagement with BIPOC communities.

The Washington State Opioid Response Grant II (SOR II)
September 30, 2020, through September 29, 2022.

SOR II: Washington State Allocation: $27,173,792 per year/Two-year grant. Total contracts: $25,884,193

- Prevention $5,157,375
- Data $56,467
- Treatment $15,221,375
- Recovery Support Services $5,062,184

Prevention—$5,157,375

1. **Community Prevention and Wellness Initiative (CPWI) Expansion (**SOR II $3,514,927) – P1 (opioid response plan strategy 1.1) P1

Description: Fund 40 current high-need communities with the greatest risk for youth opioid and stimulant use. CPWI communities use SAMHSA's Strategic Prevention Framework (SPF) for planning, implementation, and sustainability of the coalition and evidence-based programs. Each CPWI site receives a full-time Student Assistance Professional (SAP) through local Education Service Districts (ESD) who provides school-based prevention and intervention services. The Department of Social & Health Services, Research and Data Analysis (RDA) will create community data books to facilitate local needs assessments and strategic planning. DBHR partners with WA State University (WSU) for the expansion of the Fellowship Program for 10-12 entry-level prevention professionals, building community capacity for local sites to implement CPWI and begin the strategic planning process of the SPF. Funds will also support up to seven capacity-building grants for new high-need communities in WA to conduct a local strategic planning process, including a needs and resources assessment, gap analysis, and community organizing.

Fellowship Program

Description: DBHR has contracted with Washington State University (WSU) to manage and co-develop the Washington State Fellowship Program. The 10-month Fellowship Program goals are to increase the prevention workforce for Washington State by providing Fellows with prevention system experience at both the state and community level.0 and build capacity within high-needs communities to implement prevention services. Each Cohort will spend 3 months with DBHR in Olympia, WA gaining intensive state-level prevention experience, then will spend 3 months mentoring and shadowing with an existing CPWI site, and then spend the last 4 months of their Fellowship with a new high-needs community beginning the CPWI Strategic Prevention Framework model.

2. **Community Enhancement Grants (**SOR II $452,638) – P2 (opioid response plan strategy 1.5)

Description: Prevent opioid use disorder by funding 13 community-based organizations serving 39 high-need communities. Activities include direct evidence-based prevention services, information dissemination, and environmental strategies including the promotion of secure disposal and safe home storage of opioids.

3. **Starts with One Public Education Campaign** (SOR II $908,184) – P3 (opioid response plan strategy 1.4)

Description: DBHR will contract with Desautal Hege to enhance, implement, and evaluate the statewide Starts with One public education campaign. This includes hands-on tools for community prevention providers, content on never sharing prescription medication and how to have a conversation with a friend/peer about the dangers of opioids. Campaign messaging may also expand to include the prevention of stimulants (such as Adderall and Ritalin) among youth and young adults.

4. **UW TelePain – (**SOR II $41,000) **–** P4

Description: Provide partial funding to the University of WA for a weekly TelePain program for access to a multidisciplinary panel of experts who provide didactic teaching and case consultation to primary care providers to reduce overdose-related deaths by improving the knowledge and prescribing practices of primary care providers.

5. **WSU Contracted Services** (SOR II $125,000) – P5 – This is combined with T7.

6. **Opioid Summit –** (SOR II $97,709) – P6

Description: DBHR is currently planning the Region 10 Opioid Summit to provide education and open dialogue with state, tribal, behavioral health, medical providers, and community providers to reduce opioid use disorder. The Summit will be held in partnership with Idaho, Alaska, and Oregon. There will be a specific component to include interventions such as naloxone, harm

reduction, and other topics that support the continuum of prevention, treatment, and recovery. DBHR is currently putting together a broader planning group and individual subgroups for the coordination of breakout sessions and speakers. We will also ensure that populations such as rural communities, criminal justice, and tribal communities have representation within presentations and/or panels.

7. **Workforce Development Enhancements (**SOR II $20,000**) –** P7

Description: Enhance funding for the annual 2022 WA State Prevention Summit to increase professional development opportunities for youth and prevention professionals through opioid prevention workshops. Contract with University of Nevada Reno for conference logistics.

8. **Analysis of Evidence Based Practice (EBP) Project –** (SOR II $35,000) P8

Description: Contract to update the evidence-based program registry and outline of allowable EBPs for dissemination to the prevention field. Includes costs for updates to the technology and website needs on the Athena Forum ($5000) through WA-Tech, as well as a contract with the Washington State Institute on Public Policy, Washington State University, PIRE, or Rodney Wambeam out of the University of Wyoming.

Data -- $443,220

1. (D1) Community prevention evaluation (SOR II $20,000)**:** Contract with WA State University (WSU) to develop and disseminate community and state level reports for ongoing CPWI Evaluation. Contract may include collection, synthesis, and/or reporting of data in various formats.

2. (D2) Substance Use Disorder and Mental Health Promotion Online Reporting System (Minerva) (SOR II $20,000)**:** Support the development and maintenance of the system to track local data on prevention services, feeding into the overall evaluation of community prevention services.

3. (D3) Research & Data Analysis Division: Contract with RDA for project evaluator, programmer analyst, and GPRA coordination services for data evaluation.

Treatment—$15,221,375

1. **Opioid Treatment Networks** – ($7,098,765**)** – T1 (opioid response plan strategy 2.2)
DBHR has contracted with 15 organizations (consisting of 7 emergency departments, 5 jails, 1 syringe exchanges, 1 shelter, and 1 fire department) to create Opioid Treatment Networks (OTNs) to provide: medication for individuals experiencing opioid use disorder (OUD); funding to build OTN infrastructure; funding for staff; funding for OUD medications; and facilitation to transition individuals to community providers. Initiation sites are the funding recipients and

contract holders – distribution of funding to OTNs was prioritized based on data of highest need and location of project to reach the populations at most risk for overdose and death. Contracts are performance-based, and are based on the number of new inductions, retention and OTN size.

(For FFY 2021, there will be 14 OTNs - $302,975 moved to T14, Contingency Management Training).

1. **Contingency Management Training** (FFY 2021 only - $302,975 from T1)
   CM is an evidence-based behavioral intervention for substance use disorder. It provides incentives to individuals contingent upon objective evidence of the target behavior, such as a negative urine drug test, to increase the likelihood of these behaviors, which are essential components and outcomes of effective treatment. This contract will provide for training and fidelity monitoring of the OTNs and H&S.

2. **OTN TA/Training** – ($500,000 SOR) – T2 (opioid response plan strategy 2.2)
   DBHR is entering into a performance-based contract with the University of Washington, Alcohol and Drug Abuse Institute (ADAI) to provide technical assistance and training to support OTN development and monitoring.

3. **OTN Tobacco Cessation - T4 – (**$459,000- Tobacco Cessation @$329,000 and One FTE @$130,00)
   DBHR contracts with the Department of Health (DOH) to provide services for SOR projects and SOR funded clients, including WA Tobacco Quitline services, such as phone counseling and nicotine replacement therapy, Tobacco Treatment Specialist (TTS) training for SOR contractor's staff and training for providers on cross-addiction and Quitline referrals processes.

4. **Grants to Tribal Communities –T5 -** $372,500 (opioid response plan strategy 1.1)
   Tribal prevention and treatment grants to 21 tribes @ 12,500 each total $262,500 and 2 Urban Indian Health Programs ($100,000), are designed to meet the unmet needs of previous state opioid tribal requests. Development of a Tribal Opioid Epidemic Response Workgroup ($10,000). (For FFY 2021, $50,000 moved to Opioid Summit P10)

5. **OUD Treatment Decision Re-entry Services & COORP –** ($1,981,352 SOR II – T6 (opioid response plan strategy 2.4)
   WA-Opioid STR together with the Department of Corrections (DOC) has developed and is operating two programs. The reentry work-release and violator programs are in five communities across Washington State and provide re-entry services for discharging work-release and parole violators who have been identified as having OUD. The second program; Care for Offenders with OUD Releasing from Prison (COORP), identifies incarcerated individuals with OUD, expected to be released, and connects individuals to medication for opioid use disorder (MOUD) services in the county of their release, and expedites their enrollment in a Medicaid health plan.

6. **Tribal Treatment** – T8 SOR II $120,000
   Description: Create and distribute media campaigns for tribes to build awareness related to MAT/OUD treatment options for Native Americans ($131,511). The goal of the project is to work collaboratively with recognized tribal governments to engage in MAT services.

7. **WSU Contracted Services** – ($521,557 SOR**)** – T7 and P5 combined
   Contracted WSU Position for 1.0 FTE Treatment Manager, responsible for contract monitoring and training related to subrecipient grantees and state partners funded with the SOR. This position will be an integral part of the current substance use disorder and mental health treatment team as they will ensure all SOR treatment works in tandem with current treatment efforts and prevents service duplication. 1.0 FTE for Communication Lead to manage media for SOR. 1.0 FTE Prevention Services Manager position responsible ensuring all SOR prevention works in tandem with current efforts and prevents service duplication.

8. **Opioid Treatment Network Hub & Spokes –** ($4,437,324 SOR) **–** T3
   Description: DBHR utilizing STR funding expanded access statewide access to MAT by developing and implementing a six Hub & Spoke model. SOR supplemental funding will maintain and augment the model. Hubs are regional centers serving a defined geographical area that support spokes. Hubs will be responsible for ensuring that at least two of the three Federal Drug Administration (FDA) approved MATs are available. Spokes (five per hub) are facilities that will provide behavioral health treatment and/or primary healthcare services, wrap around services, and referrals to patients referred to them by the hub. The goal of the project is to increase access to MAT services statewide.

Recovery Support Services - $5,062,184

1. **OUD and MAT Training to Community Recovery Support Services** ($15,000 SOR II + SOR I NCE $14,696) – R1 (opioid response plan strategy 2.2.5)
   TA/training will be provided to staff at: Catholic Community Services in Burlington, Everett Recovery Café, Peer Washington, Comprehensive Healthcare in Walla Walla, Okanogan Behavioral Healthcare, Spokane Recovery Café, and Vancouver Recovery Café. Recovery Support Staff will be provided training costs and expenses to attend the Region X Opioid Symposium.
2. **Client-directed Recovery Support and Peer Services** ($3,531,212 SOR II) – R2 & R3 (opioid response plan strategy 2.2.5)
   Contracted direct recovery support and peer services to Catholic Community Services in Burlington, Everett Recovery Café, Peer Washington, Comprehensive Healthcare in Walla Walla, Okanogan Behavioral Healthcare, Spokane Recovery Café, and Vancouver Recovery Café. Recovery support services will be person directed and will include peer services/recovery coaching, and recovery planning. Additional services (employment support, housing support, mentoring, dental care not covered by Medicaid, medical care

not covered by Medicaid, basic needs, education support, etc.) will be based on each individual's need and request for support.

3. **PathFinder Peer Project** ($1,505,972 SOR) – R4
   Description: Provide outreach and engagement services to individuals who are homeless/risk of homelessness and suspected of Opiate Use Disorders (OUD) and/or Stimulant Use Disorder (SUD) in two environments, emergency rooms and homeless encampments. Assist individuals with suspected OUD/SUD to access Medication for Opiate Use Disorder (MOUD) Services, Intensive Out/In patient SUD treatment, access Medicaid and other governmental funding such as SNAP.

Washington State Project to Prevent Prescription Drug/Opioid Overdose (WA-PDO)

A collaborative five-year project between DBHR and the University of Washington Alcohol and Drug Abuse Institute (ADAI) with the purpose of preventing opioid overdose and deaths from opioid overdose, and building local infrastructure to plan, implement, evaluate, and fund overdose prevention efforts in the long-term. $1,000,000 per year for 5 years.

Naloxone Distribution: University of Washington Alcohol and Drug Institute: Washington State Project to Prevent Prescription Drug/Opioid Overdose (WA-PDO) Grant – 2016 to 2021

Naloxone distribution to 5 High Need Areas (HNA) across Washington State. Each HNA includes multiple counties. Kit distribution started in January 2017.

January 2017 to August 2021 Individuals Trained:	16,214
Naloxone Kits Distributed:	55,155 (includes refills)
Overdose Reversals:	9,190

This grant completed on August 30, 2021.

Washington State Project to Prevent Prescription Drug/Opioid Overdose (WA-PDO)

A collaborative five-year project between DBHR and the Washington State Department of Health with the purpose of preventing opioid overdose and deaths from opioid overdose, and building local infrastructure to plan, implement, evaluate, and fund overdose prevention efforts in the long-term. $850,000 per year for 5 years.

Naloxone Distribution: Washington State Department of Health: Washington State Project to Prevent Prescription Drug/Opioid Overdose (WA-PDO) Grant – 2021 to 2026

Naloxone distribution to 5 High Need Areas (HNA) across Washington State. Each HNA includes multiple counties, for a total of 18 partner agencies.

<u>Year 1</u>: (September 2021 to August 2022)

Individuals Trained: 2,721
Naloxone Kits Distributed: 12,494 (includes refills)
Overdose Reversals: 1,957

Year 2: (September 2022 to March 2023 – most current data)
Individuals Trained: 2,633
Naloxone Kits Distributed: 17,861 (includes refills)
Overdose Reversals: 2,366

This grant continues through August 30, 2026.

Washington State Department of Health (DOH)
December 1, 2018 through September 30, 2019 ($864,000)
October 1, 2019 through September 30, 2020 ($864,000)
October 1, 2020 through September 30, 2021 ($864,000)
October 1, 2021 through September 30, 2022 ($864,000)
October 1, 2022 through September 30, 2023 ($864,000)
October 1, 2023 through September 30, 2024 ($2,500,000)
October 2, 2024 through September 30, 2025 ($2,500,000)

Funding from the SABG is allocated for naloxone distribution. This was part of the sustainability plan to continue naloxone distribution statewide after the original WA-PDO grant ended August 31, 2021. There was an initial set of requests for 10,344 kits (both nasal and intramuscular) from 32 requesters in March and April 2019. DOH began distribution in April 2019.

April 2019 to September 2019: 7,527 kits distributed, 3,468 individuals trained, and 459 reported overdose reversals.

October 2019 to September 2020: 12,540 kits distributed, 7,204 individuals trained, and 2,185 reported overdose reversals.

October 2020 to September 2021: 21,204 kits distributed, 8,730 individuals trained, and 4,383 reported overdose reversals.

October 2021 to September 2022: 31,020 kits distributed, 14,129 individuals trained, and 5,599 reported overdose reversals.

October 2019 to most current data through March 2023: 25,350 kits distributed, 12,318 individuals trained, and 4,040 reported overdose reversals.

Co-Occurring Disorders

DBHR convened a workgroup to begin creating a plan, process, and structure that supports treatment and recovery for individuals who experience a substance use and mental health disorder. Individuals who experience a co-occurring disorder (COD) have one or more substance use related disorders as well as one or more mental health related disorders.

The workgroup agreed that the plan for a co-occurring WAC should be looked at but there was not enough time to make the needed changes by July 1, 2018. Creating a single set of rules would accomplish the goals of the workgroup as required by House Bill 1819 and stay within DBHR scope of authority. The certification responsibilities moved to the Department of Health July 2018.

The group considered definitions associated with substance use related disorders, mental health disorders, co-occurring disorders, and programs these definitions are included in TIP 42. Key issues considered included integrated screening, assessment, and treatment planning although current WAC related to previous legislation requires the use of the GAIN SS screening for both MH and SUD issues and a co-occurring assessment. Individuals with COD are best served through an integrated service plan that addresses both substance use and mental health disorders in one or program or at the same time with an integrated plan.

The integrated WAC was completed and implemented statewide, as mentioned the group agreed that work on a co-occurring WAC would not be able to be accomplished in the time allowed.

Effective July 2, 2020, Washington state implemented a Behavioral Health Co-Occurring Disorder Specialist enhancement under the Washington Administrative Code. WAC 246-804 defines a Co-Occurring Disorder Specialist as an individual who possesses “an enhancement granted by the department under chapter 18.205 RCW and this chapter that certifies the individual to provide substance use disorder counseling subject to the practice limitations under RCW 18.205.105.” In addition, the recent code created an application process through which an individual can apply for the enhancement credential. There are specific training standards which have to be met for someone to qualify for the enhancement.

Beginning in 2020, we began working on a substantial overhaul to our Medicaid state plan to modernize our rehabilitative services section, which is the main section leveraged by our licensed behavioral health agencies. Historically, this section was written in two siloes by different state agencies; 1) mental health services; and 2) substance use disorder services. Under integrated care, the state plan is now fully overseen by the HCA. Over the past year, we have received technical assistance from CMS and have collaborated with our tribal partners and key stakeholders to develop a draft state plan amendment to be submitted to CMS in July 2023. This state plan amendment is written in a more cohesive manner, to intentionally avoid siloing mental health and substance use disorder treatment. The new format paves the way for more strategic planning around true co-occurring services. Additionally, specific services, such as stabilization services and community

integration have been broadened to allow for additional provider types such as substance use disorder professionals. Allowable provider types for substance use have also been broadened to both align and recognize the full scope of practice for licensed counselors and social workers, further paving the way for more integrated care and flexible use of our limited workforce. Once approved by CMS, the state plan amendment will go into effect January 2024. As we move forward into 2024-2025, the next phase of our work will involve close collaboration with our tribal partners and stakeholders to consider additional changes to the state plan and existing Washington Administrative Codes to further bolster, define, and expand co-occurring services. Listening and collaboration with those who have received or are receiving services, as well as peers and others with lived experience will also be key to this work.

In summary, there are several workstreams and options to be considered as a multi-pronged approach to co-occurring services. These options include but are not limited to future state plan amendments, rule revisions, program development to better define co-occurring care, as well as collaboration with our payors and actuaries around different contracting and payment bundles that best support co-occurring services.

IDENTIFY THE UNMET SERVICE NEEDS AND CRITICAL GAPS WITHIN THE CURRENT SYSTEM

*This step should identify the unmet service needs and critical gaps in the state's current systems, as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's behavioral health system, including for other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps. The state's priorities and goals must be supported by data-driven processes. This could include data that is available through a number of different sources such as SAMHSA's National Survey on Drug Use and Health (NSDUH), Treatment Episode Data Set (TEDS), National Survey of Substance Use Disorder Treatment Services (N-SSATS), the Behavioral Health Barometer, **Behavioral Risk Factor Surveillance System (BRFSS)**, **Youth Risk Behavior Surveillance System (YRBSS)**, the **Uniform Reporting System** (URS), and state data. Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States with current Partnership for Success discretionary grants are required to have an active SEOW.*

*This narrative must include a discussion of the unmet service needs and critical gaps in the current system regarding the MHBG and SUPTRS BG priority populations, as well as a discussion of the unmet service needs and critical gaps in the current system for underserved communities, as defined under **EO 13985**. States are encouraged to refer to the **IOM reports**, Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement and **The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding**[1] in developing this narrative.*

WASHINGTON STATE NEEDS ASSESSMENT

Washington State integrated substance use disorder and mental health purchasing in April 2016 and completed the process of moving to integrated care with primary health in January of 2020. These changes have driven substance use disorder treatment services from a fee-for service program to a managed care model which required changes in how data is being collected. Due to the change, the MHD-CIS and TARGET data systems needed to be replaced by an integrated Behavioral Health Data System (BHDS) and Provider One (claims-based data system).

The one caveat to the integration is with the Tribal government, who through a 2016 consultation requested to maintain the TARGET system for data collection, until a data solution is found in collaboration with Tribes. Therefore, tribes serving Native and non-Native individuals within their community will continue to report these encounters in TARGET

The BHDS system has modernized the flow of data, provided increased security, improved accountability, and increased transparency of information, which will assist in refined management decisions and policy development. This system has also strengthened the monitoring and quality of the service delivery system, enhanced outcome analysis for the entire organization, and will further align the organization to a managed care model while maintaining Division of Behavioral Health and Recovery's (DBHR) ability to track priority outcomes, such as employment and housing for adults with serious mental illness (SMI). Through legislative direction in 2013, Research and Data Analysis (RDA) created a dashboard to measure the outcomes of the system. Using their Integrated Client Data system RDA is able to match administrative data records from multiple administrative data systems including BHDS to provide and measure outcomes. This same legislation (2SSB5732) also directed the Washington State Institute for Public Policy (WSIPP) in partnership with DBHR to create an inventory of evidence-based, research-based, and promising practices of interventions in adult mental health and substance use treatment services.

To make data-informed needs assessments with planning, policy development, service provision, and reporting DBHR continues to integrate stakeholder input, including input from the Behavioral Health Advisory Council, as well as the independent peer review summaries. Additionally, the State Epidemiological Outcomes Workgroup (SEOW) plays an important role in primary prevention planning. The SEOW fosters collaboration across Washington State agencies and partners in surveillance and research to inform program planning to reduce substance abuse and promote mental health in Washington State. The SEOW is sponsored by DBHR and supports agencies and partners in Washington State by collecting, interpreting, reporting, and advising on epidemiological and client service information that facilitates data-guided decision making among agencies and partners. Members of SEOW meet quarterly and membership includes data experts, epidemiologists, and evaluators from multiple state agencies,

universities, as well as the Urban Indian Health Institute. DBHR is committed to ensure that tribal behavioral health needs define statewide needs by including representatives from the Northwest Portland Area Indian Health Board Epidemiological Center and the Urban Indian Health Institute as members for the SEOW. The SEOW collects and provides guidance on the collection of data related to substance use and mental health, including consumption and prevalence, consequences of use, and intervening variables. Data is sourced from both national and state surveys and administrative databases and is collected statewide covering all age and demographic groups. To allow for more in-depth geographic analysis, data are maintained at the lowest geographical level possible which allows Washington to support community-based initiatives. The SEOW serves as the primary data workgroup for the Washington State Prevention Enhancement (SPE) Policy Consortium's State Substance Abuse Prevention and Mental Health Promotion Five-Year Strategic Plan. Using a data-based approach, the Washington State Prevention Enhancement (SPE) Policy Consortium is updating the state's Substance Use Disorder Prevention and Mental Health Promotion Five-Year Strategic Plan, to completed in July 2023. The SPE Policy Consortium is comprised of representatives from over 20 state and tribal agencies and organizations. The goal of the Consortium is that through partnerships Washington will strengthen and support an integrated system of community-driven substance use disorder prevention programming, mental health promotion programming, and programming for related issues. The current State of Washington Substance Use Disorder and Mental Health Promotion Five-Year Strategic Plan was developed in 2012. It was updated in 2015, 2017, and 2019 and both past plans and the current plan are posted ~~at~~ on the Athena Forum~~.~~ The SPE Policy Consortium has just completed an in-depth five-year strategic planning process, undergoing a needs and resources assessment, diving deep into the community and state level workforce and training needs, and identifying policy and programmatic areas that need a greater focus in the next five years, such as dedicating efforts to support populations of focus with substance use disorder prevention and mental health promotion programs, and implementing environmental strategies to reduce access and availability of substances

Strategy to Identify Unmet Needs and Gaps

DBHR's Recovery Support Services utilizes the Peer Support Advisory Group to inform HCA of needs and gaps around training and certifying peers. Some of these topics include increasing the diversity of HCA approved trainers and training organizations and updating and creating curriculum that meets the needs of the peer workforce. Recovery Support Service program managers do site visits and solicit voice of the people receiving the services to identify strengths and barriers to services. In SFY 2022 the Recovery Support Services in partnership with the Office of Recovery Partnerships held listening sessions across the state with three marginalized populations to include, Black, Hispanic, and AI/AN. These listening sessions collected information on strengths and barriers in accessing and receiving services.
HCA supports the American Indian/Alaska Native Opioid Response workgroup, in partnership with the American Indian Health Commission. This workgroup discusses successes, strengths, and gaps within the system to address the opioid crisis and significantly higher rates of opioid and fentanyl use disorders, overdoses, and deaths. The Native Transformation project

conducted by the Northwest Indian College and 3 Tribes in the north sound region, identify protective factors for opioid prevention and recovery. In 2023, Tribal elected leaders and the state governor sat together to discuss solutions needed to address this significant crisis and follow up work will be needed to implement those strategies.
DBHR utilizes a number of local reports that indicate need and usage of the inpatient, Involuntary Treatment Act (ITA), and crisis systems. This information informs planning to address gaps in inpatient, crisis, and diversion capacity. This information also informs the work that DBHR is doing to shift long term involuntary treatment from the state psychiatric hospitals to contracted community settings.

DBHR's planning of prevention and treatment services draws on data from various sources. The biennial statewide **Healthy Youth Survey (HYS)** provides reliable estimates of substance use prevalence and mental health indicators as well as risk factors that predict poor behavioral health outcomes among adolescents in grades 6, 8, 10, and 12. The survey, supported by four state agencies and in over 80 percent of the state's public schools, is used by DBHR to estimate prevalence rates at state, county, Behavioral Health Organizations, Accountable Communities of Health, school districts, and school building levels. After a postponement of 2020 HYS due to the COVID-19 pandemic, the most recent HYS was conducted as an electronic survey in the fall of 2021 and provided data for DBHR's needs assessment, including broadening surveillance capacity for LGBTQ+ communities, adolescent anxiety, and substance use issues related to vapor products. The next HYS will be administered in fall 2023 and include expanded reporting capacity including an online data dashboard.

The HCA has partnered with state agencies tribal liaisons to develop a plan to improve tribal engagement and data accessibility for tribal health and school partners. We have also invested in support to hire a fellow that will help this sub workgroup complete tasks outlined in this plan.

For young adults, adults, and older adults, the main data sources for prevalence estimates and epidemiological analyses are **the National Survey on Drug Use and Health (NSDUH),** the **Behavioral Risk Factor Surveillance System (BRFSS)**, and the **Washington Youth Adult Health Survey (YAHS)**. NSDUH is used to estimate and monitor substance use prevalence rates for various types of substances and BRFSS provides information to identify needs and gaps among various demographic and socioeconomic subpopulations. For example, the Washington BRFSS includes questions that allow us to identify pregnant/parenting women and the LGBTQ subpopulations. However, the small sample size limits the ability to create estimates for these subpopulations without combining multiple years of data, and the minimal number of questions about cannabis and alcohol on these surveys limits the ability to assess how recent policy changes are shaping substance use patterns. DBHR has partnered with researchers at the University of Washington to conduct the YAHS as an expansion to the State's Healthy Youth Survey (HYS). The YAHS measures cannabis and other substance use, perceptions of harm, risk factors, and consequences among young adults (18 to 25 years old) living in Washington State. The SEOW member agencies and partners advise survey development and implementation. The

SEOW will continue to assess data for priority populations and advise on potential data sources to address these gaps.

The use of evidence-based practices (EBP) in the field of behavioral health is very well established. The Washington State Legislature has acknowledged the importance of EBPs in children's mental health and adult behavioral health services. DBHR has established a partnership with the University of Washington's Evidence-based Practice Institute (EBPI) to assess the need for evidence-based practices in the children's behavioral health system. The collaboration aims to formulate EBP reporting guidelines and to monitor the use of EBPs by providers and identify gaps in EMP implementation using data from BHDS. As mentioned earlier the Washington State Institute for Public Policy (WSIPP) identified a three-step process for identifying EBP, RBP and PP for adult behavioral health services through a rigorous meta-analysis of the research, costs and return on investment of the intervention and conducting a risk analysis of the results. Through this work, HCA has also learned and understands the need to support promising and tribal best practices along with EBPs.

Primary prevention services are chosen by sub-recipients from a list of approved evidence-based programs and strategies created by Washington State's Evidence-Based Program Workgroup (EBP Workgroup). The list is posted on the Athena Forum website (https://www.TheAthenaForum.org/EBP). The EBP Workgroup is comprised of researchers and experts from University of Washington's Social Development Research Group and Washington State University's Improving Prevention through Action Research Lab, with input from the Washington State Institute for Public Policy, the prevention research sub-committee, and Pacific Institute for Research and Evaluation. The list was developed with programs and strategies that came from three primary resources: the National Registry for Evidence-based Programs and Practices (NREPP), a separate list of programs identified as evidence-based by the State of Oregon; and the Pacific Institute for Research and Evaluation's (PIRE) "Scientific Evidence for Developing a Logic Model on Underage Drinking: A Reference Guide for Community Environmental Prevention" report.

For specific priority subpopulations, including persons using intravenous drugs and pregnant, person with a substance use disorder and pregnant, persons who use intravenous drugs, and women with dependent children, data will be drawn from other state surveys and administrative databases as well as service data to identify the un-met need. For example, we will use data from the **Pregnancy Risk Assessment Monitoring System (PRAMS)** to estimate the prevalence of substance use among pregnant women and treatment data to identify the rate of treatment for persons who use drugs while pregnant. When prevalence data is unavailable for certain priority subpopulations, such as women with dependent children, treatment data will be used to monitor rates of admission to SUD treatment. The SEOW will identify data gaps for priority subpopulations and advise on potential data sources. At the sub-state level, we will use a synthetic process to estimate substance abuse treatment needs. This process combines data from US Census sources for geographic and demographic subgroups to "expand" the NSDUH state-level estimates of AOD treatment need into the desired subgroups (defined by poverty level, age, race/ethnicity, gender). Detailed community level needs and resources assessments

will be used to develop strategic plans to support the individual, community, and local system level. In addition to HYS, the **Community Outcomes and Risk Evaluation (CORE) System** will be used in community level needs assessments to include updating an annual risk ranking to aid DBHR in identifying high-need communities to target prevention services. In this process, HYS and archival data on key substance use and consequence indicator from the CORE Geographic Information System (GIS) are used to create a county-level risk profile and a community-level composite risk score for each community where school district service areas are the proxy. Communities are ranked statewide and assigned a percentile ranking according to their risk level based on the composite risk score. The CORE GIS, developed as a set of social indicators highly correlated with adolescent substance use, are kept at the lowest possible level (at least county level, and address level in some instances). Most indicators originate from the Department of Health (including the Prescription Monitoring Program), DSHS, the Uniform Crime Report, and the Office of Superintendent of Public Instruction. The most recent update was in spring of 2021. Due to HYS and CORE data available at the community and school level, communities and neighborhoods can be identified that otherwise might be overlooked if data were only available at larger geographic units.

In 2021, the WA State legislature passed SB 5476 in response to the state Supreme Court ruling that the state's current drug possession laws were unconstitutional and directed HCA to assemble the Substance Use Recovery Services Advisory Committee (SURSAC) to collaborate with HCA to write a new Substance Use Recovery Services Plan for the state. In 2022, the SURSAC met monthly with HCA to discuss needs within the SUD continuum of care in Washington State and made several recommendations to address them, which were submitted to the legislature at the beginning of 2023, for consideration during the 2023 legislative session. Most of the recommendations were adopted and funded via the state budget bill (SB 5187) and/or the new "Blake" bill, SB 5536. The adopted recommendations span housing needs (e.g., investing in and incentivizing recovery residences), bolstering efforts to divert people who use substances from entanglement in the criminal legal system (e.g., investments to support and expand LEAD, AJA, and RNP), and building out harm reduction and treatment infrastructure (e.g., piloting Health Engagement Hubs for people who use drugs, expanding opioid treatment programs and medication units, especially in rural areas), and ensuring that the impact of these investments can be assessed through new data infrastructure and reporting requirements.

Strategy to Align Behavioral Health Funding with Unmet Needs and Gaps

The funding allocation methodology for non-Medicaid services was reviewed as part of the integration of mental health and substance use disorder treatment for the Behavioral Health Organizations. Treatment needs by county, as well other factors such as county population, utilization patterns, penetration, and retention rates were also used for developing the methodology. After much review with stakeholders, the final methodology that was incorporated into the model is 70% prevalence, 20% penetration and 10% retention. Integrating these factors allows us to maintain focus on priority populations and the full continuum of care.

Mental health resource allocation will continue to be based on prevalence and treatment needs. For example, DBHR recently updated the state hospital bed allocation formula with current prevalence rates of serious mental illnesses and prior utilization rates.

Prevention funding, under the state's Community Prevention Wellness Initiative (CPWI) and through grants awarded to Washington State community-based organizations (CBOs), are targeted to communities with the highest needs. In addition to **HYS**, the **Community Outcomes and Risk Evaluation (CORE) System** is used in to aid DBHR in identifying high-need communities to target prevention services. CPWI is unique in its approach to community selection because CPWI uses a data-informed community selection process. When funding is available, high-need communities according to their risk ranking, are eligible to apply.

Prioritize State Planning Activities

Priorities

Priority 1: Address High Disproportionate Rates of SUD and MH Disorders and Overdoses Amongst AI/AN/Individuals in WA State.
American Indians/Alaska Natives disproportion SUD and overdose rates continue to be a priority for HCA to address in partnership with tribal governments and urban Indian health organizations. This goal is focused on addressing these rates by offering a direct allocation to Tribes through our government-to-government Indian Nation Agreements.

Priority 14: Increase the number of adults receiving opioid use disorder treatment, support during recovery from OUD, and tools necessary to reduce deaths resulting from opioid overdose and poisoning.
HCA is committed to increasing the accessibility of treatment for individuals experiencing opioid use disorder, support individuals in recovery from opioid use disorder and reduce the harms associated with opioid use and misuse.

Priority 2: Reduce Underage and Young Adult Substance Use/Misuse.
The State Prevention Policy Consortium concluded that underage drinking remains the top priority for substance abuse prevention and mental health promotion for youth and adults. Marijuana ranked second due to high prevalence among youth. Depression, anxiety, and suicide prevention were also identified as behavioral health areas for which increased attention to capacity building is needed in support of mental health promotion. Tribal programs suggest that heroin is the drug of choice among youth on some reservations based on the analysis of these issues among sub-populations and in their own local assessments. Substance abuse prevention and mental health promotion should both focus on youth and young adults.

Priority 3: Increase the number of youths receiving outpatient substance use disorder treatment.

Priority 9: Increase the number of adults receiving outpatient substance use disorder treatment.
Issues around access, service timeliness, and engagement continue to be a focus of substance use disorder treatment services as the state supports integration of behavioral health services. The updated funding formula based on prevalence, penetration, and retention integrates the focus on the mandated priority populations (IVDU, PPW) and full continuum of care, while retaining the commitment to youth treatment, evidence-based practices, and statewide availability of services.

Priority 4: Increase the number of SUD Certified Peers.
HCA developed a peer support program to train and increase the number of SUD peers working in the field to incorporate SUD peer services into the behavioral health system.

Priority 5: Maintain outpatient mental health services for youth with SED.
Priority 7: Maintain the number of adults with SMI receiving mental health outpatient treatment services.
Mental health treatment services continue to focus on the block grant priority population: youth, adults, and older adults with serious emotional disorder (SED) or serious mental illness (SMI).

Priority 13: Increasing access to Behavioral Health Crisis Services through expansion of voluntary mobile crisis services.
HCA is focused on expansion of access to crisis services and reduction of unnecessary use of first responders and emergency departments to improve outcomes for those in crisis by providing ongoing stabilization services.

Priority 6: Increase capacity for early identification and intervention for individuals experiencing First Episode Psychosis.
HCA is committed to increasing the number of mental health community-based agencies who serve youth diagnosed with First Episode Psychosis.

Priority 8: Increase the number of individuals receiving recovery support services, including increasing supported employment services and supported housing services for individuals with SMI, SED and SUD.
HCA is committed to decreasing rates of homelessness and increasing rates of employment for adults with behavioral health issues while increasing awareness and using evidence-based practices to address these needs through our supported housing and supported employment programs. HCA would like to develop developmentally appropriate outreach and integration of supported employment and supported housing services for older youth and young adult populations.

Priority 10: Pregnant and Parenting Individuals with Dependent Children.
Pregnant and parenting individuals continue to be a priority population for substance use disorder services to improve their health and assist in maintaining recovery.

Priority 11: Tuberculosis Screening
Provide Tuberculosis screening at all SUD outpatient and residential provider agencies within their provider networks.

Priority 12: Workforce Innovation
Workforce shortages within Washington state continue to present challenges in meeting the service needs for individuals with mental health disorders, substance use disorders and co-occurring disorders. Prioritizing workforce education and training and supporting awareness of and promotion of behavioral health careers is a high priority through the StartYourPath.org campaign.

Development of Goals, Objectives, Performance Indicators and Strategies

Table 1: Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Address high disproportionate rates of SUD and MH disorders and overdoses amongst AI/AN individuals in WA state.
Priority Type: SUP- Substance Use Prevention, Substance Use Treatment (SUT), Substance Use Recovery (SUR).
Population(s): Behavioral Health Crisis Services (BHCS), American Indian/Alaska Native individuals who are Pregnant Women and Women with Dependent Children (PWWDC), AI/AN pregnant and parenting individuals (PPI), AI/AN Persons who Inject Drugs (PWID), AI/AN individuals with Tuberculosis (TB)

Goal of the priority area:
The goal of this priority is to address the disproportionately high rates of SUD and MH disorders for AI/AN individuals across the state. This goal is focused on addressing these rates by offering a direct allocation to Tribes through our government-to-government Indian Nation Agreements. The INA is an agreement between the HCA and Tribal governments to fund services as deemed appropriate by the Tribes to address substance use disorders using SABG dollars.
The Health Care Authority follows the RCW 43.376 and a communication and consultation policy which outlines the state regulations for G2G relationships with Tribes. The Office of Tribal Affairs assists DBHR in implementation of various consultation and confirm meetings with the 29 Tribes and urban Indian health programs. By extension of the Accord and our HCA Tribal Consultation Policy, HCA offers all 29 Tribes the opportunity to access substance abuse block

grant funding to help bolster prevention, treatment, overdose intervention, and recovery support services within their tribal communities.

Objective:

- Support to the Tribes to use block grant funding to begin and/or maintain tribal substance use disorder community-based prevention programs and projects for youth within tribal communities, which can include cultural prevention activities.
- Support to the Tribes to use block grant and other funding resources for the treatment and overdose intervention services for youth and adults who are non-insured or underinsured for treatment services. These services may include, case management, drug screening tests including urinary analysis, treatment support services (transportation, childcare), outpatient and intensive outpatient, and individual and group therapy, naloxone distribution.
- Support to the Tribes to use block grant funding to develop and enhance their recovery support services programs for any non-Medicaid billable services or support to individuals who are non-insured or underinsured.
- Support to the Tribes to use block grant funding to address opioid overdose and opioid use disorders in their community by delivering either OUD prevention, treatment, overdose intervention, and recovery support services.
- Support to Tribes to leverage these funding resources to prioritize their strategies as appropriate to their community to ensure culturally appropriate care and the sovereign right for the Tribes to decide how best to utilize these funds and tailor programs within their community.

Strategies to attain the objective:

- Each tribe is requested to complete an annual Tribal Plan and budget that indicates how the funding will be expended for the delivery of SUD prevention, intervention, treatment, and recovery support activities which is negotiated with HCA program managers with the support of the Office of Tribal Affairs.
- Each tribe submits quarterly fiscal and programmatic reports to HCA.
- Each tribe inputs data into each appropriate data system (i.e., TARGET Data System, and Substance Use Disorder (SUD) Prevention and MH Promotion Online Data System) on a quarterly basis with the support of HCA program managers.
- Each tribe submits an Annual Narrative Report to reflect on the prevention and treatment services provided with the funding, successes within the program, challenges within the program, etc.
- HCA coordinates a biennial desk monitoring review with each Tribe as negotiated through a formal consultation process.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Maintain substance use disorder prevention, intervention, treatment, and recovery support services to American Indian/Alaska Natives.

Baseline Measurement: SUD Treatment - Individuals Served: 3,355
SUD Prevention – Average of 51,714 total unduplicated and duplicate participants served by direct tribal prevention services provided during SFY22 (July 1, 2021 – June 30, 2022)
Opioid Treatment Programs (OTPs) within Tribes: Seven OTPs for SFY22

First-year target/outcome measurement: SUD Treatment - Individuals Served: 3,355
SUD Prevention – Increase or maintain 51,714 total unduplicated and duplicate participants in direct services prevention programs
SUD MOUD – Increase tribal MOUD and OTPs to a total of eight OTPs available in Tribal communities.

Second-year target/outcome measurement: SUD Treatment - Individuals Served: 3,355
SUD Prevention – Increase or maintain 51,714 total unduplicated and duplicate participants in direct services prevention programs
SUD MOUD – Increase tribal MOUD and OTPs to a total of ten OTPs available in Tribal communities.

Data Source:
TARGET, or its successor, for treatment counts.
Minerva – SUD Prevention and MH Promotion Online Reporting System (Washington's Prevention Management Information Service): used to report SABG prevention performance indicators.

Description of Data:
As reported into TARGET and Minerva by Tribes, total number of AI/AN clients served between July 1, 2021 and June 30, 2022.

Data issues/caveats that affect outcome measures:

- Indian Health Care Providers must enter data into multiple systems in their work to improve health information technology in their programs which is burdensome. Tribes are working to move to EHRs, are using an Indian Health Services System, plus the state data systems which are often duplicative and can be expensive to dedicate additional staff to enter data into multiple systems.
- TARGET is the system that is used by Tribes that is then transmitted into our Behavioral Health Data Store and HCA needs to sunset this system and move to a new solution for the Tribes. HCA is working on a pilot project to identify a solution to gather the SUD encounter data in the future without the TARGET system.
- SUD Prevention numbers may include duplication of client counts due to Tribes reporting number of people in attendance at events for each day.

- Additionally, the prevention reporting system transitioned to a new vendor in the fall of 2021 and Tribes had to learn a new system. HCA provides technical assistance to Tribes on the new system to minimize impact of system changes.

Priority #: 2

Priority Area: Reduce Underage and Young Adult Substance Use/Misuse
Priority Type: Substance Use Prevention (SUP)
Population(s): Pregnant Women and Women with Dependent Children (PWWDC), Pregnant and Parenting individuals (PP), Persons who Inject Drugs (PWID)

Goal of the priority area:
Decrease the use and misuse of alcohol, cannabis, tobacco, opioids or other prescription drugs, and the use of any other drugs in the last 30 days.

Note on Targets:
Targets set in the previous years were primarily based on 2018 Healthy Youth Survey (HYS) outcomes. The COVID-19 pandemic necessitated methodologic changes in data collection for surveys administered since 2020 including the HYS and the National Survey on Drug Use and Health (NSDUH). Due to these changes, we are not able to use the most recent outcomes to evaluate whether we met or exceeded targets set for 2021; we are not including the most recent outcomes as we cannot separate the effects of methodologic changes from true changes in the outcomes.
Instead, concrete targets were set based on HYS 2018 pre-pandemic data. As in previous target updates, the goal was to have 5% reductions in two-to-three years and 10% reductions in four-to-five years. Targets set for 2023 reflect previous target setting measures. For HYS 2021 pandemic-era data, statements were included to acknowledge the substantially different results and identify general directional targets.

Objective:
- Decrease the percentage of 10th graders who report using alcohol in the last 30 days (HYS 2018: 18.5%; Target 2025: 14.0%).
- Prevent the increase in the percentage of 10th graders who report using cannabis in the last 30 days (HYS 2018: 17.9%, Target 2025: 9.0%).
- Decrease the percentage of 10th graders who report using tobacco products in the last 30 days (HYS 2018 Tobacco, any form except vape: 7.9%, Target 2025: 7.1%; HYS 2018 Vape: 21.2%, Target 2025: 19.1%).
- Decrease the percentage of 10th graders who report misusing/abusing painkillers in the past 30 days (HYS 2018: 3.6%, Target 2025: 1.5%).

- Decrease the percentage of young adults who report using non-medical marijuana (cannabis) (YAHS 2021: 51.2%; Target 2025: 46.1%)
- Decrease the percentage of young adults who report using alcohol in the last 30 days (YAHS 2021: 56.9%; Target 2025: 51.2%)

Strategies to attain the objective:

- Implement performance-based contracting with each prevention contractor.
- Adapt programs to address the unique needs of each tribe.
- Strategies to serve AI/AN communities with increased risk for SUD concerns through various prevention projects using leveraged resources and ensure culturally appropriate services.
- Deliver Evidenced-based Prevention Programs and Strategies according to approved strategic plans.
- Deliver direct prevention services (All CSAP Strategies).
- Deliver community-based prevention services (Community-based process, Information Dissemination and Environmental).
- Disseminate state level public education campaigns with toolkits for localized implementation.
- Provide statewide Workforce Development Training to build capacity for service delivery.
- Develop and implement best practices strategies to target underserved populations such as Tribal and urban Indian communities, Black, Indigenous, and People of Color and LGBTQ+.
- Increase direct service programs for young adults.

Annual Performance Indicators to Measure Goal Success

Indicator #: 1
Indicator: Reduce substance use/misuse

Baseline Measurement: Average of 12,217 unduplicated participants served by direct services provided between **SFY 2020-2022** (July 1, 2020 – June 30, 2022)

First-year target/outcome measurement: Maintain a minimum of 12,217 unduplicated participants in direct services prevention programs.

Second-year target/outcome measurement: Maintain a minimum of 12,217 unduplicated participants in direct services prevention programs.

Data Source:
Minerva - SUD Prevention and MH Promotion Online Reporting System (Washington's Prevention Management Information Service): used to report SABG performance indicators.
Washington State Healthy Youth Survey (HYS): used to report 30 days use biannually.

Washington State Young Adult Health Survey (YAHS): used to report young adult (Ages 18-25) substance use/misuse.

Description of Data:
SABG performance indicators are used to measure Center for Substance Abuse Prevention Strategies and Institute of Medicine Categories for services provided annually. From HYS, 10th grade Substance Use Among Washington Youth is used to measure intermediate outcomes. From Washington State Young Adult Health Survey (YAHS), Substance Use Among Washington young adults is used to measure intermediate outcomes.

Data issues/caveats that affect outcome measures:
Data integrity can be negatively affected by staff turnover and contractor capacity to report accurately and in a timely manner. DBHR continues to provide on-going training and technical assistance to support grantees as they use the Management Information System. Additionally, the prevention reporting system transitioned vendors in Fall 2021 and all staff and providers have been learning the new system, this may increase data reporting challenges in some areas. The new system has some limitations that we are currently navigating and strategizing in order to ensure efficient, proper and accurate data entry. HCA is working to ensure all providers are supported and engaged in this process to minimize the impact.

Priority #: 3

Priority Area: Increase the number of youths receiving outpatient substance use disorder treatment
Priority Type: Substance Use Treatment (SUT)
Population(s): Pregnant Women and Women with Dependent Children (PWWDC), Pregnant and Parenting individuals (PP), Persons who Inject Drugs (PWID)

Goal of the priority area:
Increase the treatment initiation and engagement rates among the number of youths accessing substance use treatment outpatient services.

Objective:
- Require Behavioral Health Administrative Service Organizations (BH-ASOs) and Managed Care Organizations (MCOs) to continue to maintain behavioral health provider network adequacy for adolescents.
- Re-examine current adolescent network and capacity
- Improve access and increase available SUT outpatient services for youth.

Strategies to attain the objective:

- Conduct behavioral health provider mapping efforts to identify current adolescent network. Identify access challenges and strategies to remove system barriers.
- Continue using performance-based contracts with BH-ASOs and MCOs to ensure focus and oversight of provider network.
- Continue efforts to actively engage youth in a co-design project to begin reimagining what a better continuum of care for youth and young people with SUT needs.

Annual Performance Indicators to Measure Goal Success

Indicator #: 1
Indicator: Increase youth outpatient SUD treatment services

Baseline Measurement: SFY22 (July 1, 2021 – June 30, 2022): 1,690 youth received SUD outpatient treatment services

First-year target/outcome measurement: Increase the number of youths receiving SUD outpatient treatment services in SFY24 to 1,900

Second-year target/outcome measurement: Maintain the number of youths receiving SUD outpatient treatment services in SFY25 to 1,900

Data Source:
The number of youths receiving SUD outpatient services is tracked using the Behavioral Health Data System (BHDS). Note- add narrative about telehealth. Is it realistic to meet this target with the continuation of telehealth (younger)?

Description of Data:
The calendar year 2022 data is an unduplicated count of youth (persons under 18 years of age) served in publicly funded SUD outpatient treatment between July 1, 2021, and June 30, 2022.

Data issues/caveats that affect outcome measures:
DBHR has integrated behavioral health services with physical healthcare coverage, which has caused data reporting challenges. The entities submitting encounter data and how data is being submitted has changed.

Priority #: 4

Priority Area: Increase the number of SUD Certified Peers
Priority Type: Substance Use Treatment (SUT), Substance Use Recovery (SUR)

Population(s): Pregnant Women and Women with Dependent Children (PWWDC), Pregnant and Parenting individuals (PP), Persons who Inject Drugs (PWID), Tuberculosis (TB)

Goal of the priority area:
Increase the number of SUD peers working in the field, create a strategic plan to incorporate SUD peer services into the behavioral health system.

Objective:
- Pilot SUD peers
- Develop a strategic plan to review curriculum, funding strategies and rule changes

Strategies to attain the objective:
- HCA/DBHR will seek input from key stakeholders and certified peers to guide the development of a strategic plan incorporating peer services within the substance use treatment service delivery system
- Identify any curriculum adjustments needed to integrate SUD peer services
- Strategic planning to incorporate SUD peer services into the system of care, exploring funding strategies and rule changes
- Focus on diversity, equity and inclusion practices to improve diverse peer services in underserved communities.
- Increase recruitment of BIPOC Certified Peer Counselors (CPC's) and increase diversity of training organizations and CPC trainers.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: SUD peer support program

Baseline Measurement: From July 1, 2021 – June 30, 2022 total number of SUD trained peers was 488

First-year target/outcome measurement: Peer support program in SFY24 that would train 420 peers that could provide Medicaid reimbursable SUD peer services.

Second-year target/outcome measurement: Peer support program in SFY25 that would train 480 peers that could provide Medicaid reimbursable SUD peer services.

Data Source:
Monthly reports submitted to DBHR through the STR Peer Pathfinder project

Description of Data:
Excel reports indicating the number of individuals served by SUD Peers on the Pathfinder project

Data issues/caveats that affect outcome measures:
No issues are currently foreseen that will affect the outcome measures.

Priority #: 5

Priority Area: Maintain outpatient mental health services for youth with SED
Priority Type: Mental Health Services (MHS)
Population(s): Severe Emotional Disturbances (SED)

Goal of the priority area:
The primary goal is to maintain community based behavioral health services to youth who are diagnosed with SED.

Objective:
- Require the Managed Care Organizations (MCOs) and Behavioral Health – Administrative Services Organizations (BH-ASO) to improve and enhance available behavioral health services to youth.

Strategies to attain the objective:
- Require MCOs and BH-ASOs to maintain behavioral health provider network adequacy.
- Increase available MH community-based behavioral health services for youth diagnosed with SED.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Increase outpatient Mental Health services to youth with Serious Emotional Disturbance (SED)

Baseline Measurement: SFY22: 76,941 youth with SED received services

First-year target/outcome measurement: Maintain the number of youths with SED receiving outpatient services to at least 76,941 in SFY24

Second-year target/outcome measurement: Maintain the number of youths with SED receiving outpatient services to at least 76,941 in SFY25

Data Source:
The number of youths with SED receiving MH outpatient services is reported in the Behavioral Health Data System (BHDS).

Description of Data:
Fiscal Year 2022 is an unduplicated count of youth with Serious Emotional Disturbance (SED) who under the age of 18 served in publicly funded outpatient mental health programs from July 1, 2021 through June 30, 2022.

Data issues/caveats that affect outcome measures:
No issues are currently foreseen that will affect the outcome measure.

Priority #: 6

Priority Area: Increase capacity for early identification and intervention for individuals experiencing First Episode Psychosis (FEP) including FEP programs in diverse communities (I.e. Tribal Communities)
Priority Type: Mental Health Services (MHS)
Population(s): Serious Emotional Disturbance/Serious Mental Illness **(**SED/SMI)

Goal of the priority area:
The primary goal is to increase community based behavioral health services to transition age youth who are diagnosed with First Episode Psychosis (FEP).

Objective:
• Increase capacity in the community to serve youth experiencing First Episode Psychosis (FEP) through the New Journeys Program

Strategies to attain the objective:
• Provide funding to increase the number of agencies who serve youth with First Episode Psychosis (FEP)
• Increase available MH community based behavioral health services for youth diagnosed with First Episode Psychosis (FEP).

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Increase outpatient MH capacity for youth with First Episode Psychosis (FEP).

Baseline Measurement: SFY22: 12 First Episode Psychosis (FEP) Programs, serving a total of 308 youth

First-year target/outcome measurement: FY24 (July 1, 2023 – June 30, 2024) Increase the number of coordinated specialty care sites to 17 serving a total of 375 youth statewide.

Second-year target/outcome measurement: FY25 (July 1, 2024 – June 30, 2025) Maintain the 17 coordinated specialty care sites and begin implementation of adding up to three additional sites, with a total of 400 youth served statewide.
Results:

Data Source: DBHR, via reporting from WSU. Extracted from the URS reports.

Description of Data:
Number of youth being served through the coordinated specialty care sites.

Data issues/caveats that affect outcome measures:
No issues are currently foreseen that will affect the outcome measure.

Priority #: 7

Priority Area: Maintain the number of adults with Serious Mental Illness (SMI) receiving mental health outpatient treatment services
Priority Type: Mental Health Services (MHS)
Population(s): Serious Mental Illness (SMI), Behavioral Health Crisis Services (BHCS)

Goal of the priority area:
Maintain the number of adults with Serious Mental Illness (SMI) accessing mental health outpatient services.

Objective:
- Require MCOs and BH-ASOs to maintain and enhance behavioral health provider network adequacy.
- Increase available mental health behavioral health services for adults.

Strategies to attain the objective:
- Gather data and resources regarding how potential individuals are identified.

Annual Performance Indicators to Measure Goal Success

Indicator #: 1
Indicator: Maintain mental health outpatient services for adults with Serious Mental Illness (SMI)

Baseline Measurement: SFY22: 216,740 adults with Serious Mental Illness (SMI) received mental health outpatient services

First-year target/outcome measurement: Maintain a minimum of 195,046 adults with Serious Mental Illness (SMI) receiving mental health outpatient services in SFY24 (we anticipate a decrease in numbers, bringing us closer to our normal baseline pre-Covid)

Second-year target/outcome measurement: Maintain a minimum of 195,046 adults with Serious Mental Illness (SMI) receiving mental health outpatient services in SFY25 (we anticipate a decrease in numbers, bringing us closer to our normal baseline pre-Covid)

Data Source:
The number of adults with Serious Mental Illness (SMI) receiving Mental Health outpatient treatment services is tracked using the Behavioral Health Data System (BHDS).

Description of Data:
Fiscal Year 2022 clients served is an unduplicated count of adults with Serious Mental Illness (SMI) (persons 18 years of age and older) served in publicly funded mental health outpatient programs between July 1, 2021 and June 30, 2022.

Data issues/caveats that affect outcome measures:
With the combination of behavioral health services coverage, we are experiencing data reporting challenges due to the way data was collected previously.

Priority #: 8

Priority Area: Increase the number of individuals receiving recovery support services, including increasing supported employment and supported housing services for individuals with Serious Mental Illness (SMI), SED, and SUD
Priority Type: Substance Use Treatment (SUT), Substance Use Recovery (SUR), Mental Health Services (MHS)
Population(s): Serious Mental Illness (SMI), Serious Emotional Disturbances (SED), Pregnant Women and Women with Dependent Children (PWWDC), Pregnant and Parenting individuals (PP), Persons who Inject Drugs (PWID), Tuberculosis (TB)

Goal of the priority area:
Measurements for this goal will include increasing the employment rate, decreasing the homelessness rate and providing stable housing in the community.

Objective:

- Increase awareness, implementation and adherence to the evidence-based practices of permanent supportive housing and supported employment models by implementing fidelity reviews at five agencies

Strategies to attain the objective:

- Train 500 staff working in behavioral health, housing and health care, through webinars or in-person training events
- Support 1,000 individuals in obtaining and maintaining housing
- Support 1,000 individuals in obtaining and maintaining competitive employment
- Assist 25 behavioral health agencies in implementing evidence-based practices of permanent supportive housing and supported employment models

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Increase number of people receiving supported employment services

Baseline Measurement: FY2022 – 4,614 enrollments in supported employment

First-year target/outcome measurement: Increase number of people receiving supported employment services per month (over 12-month period) by 4% in FY24 (total 4,798 enrollments)

Second-year target/outcome measurement: Increase number of people receiving supported employment services per month (over 12-month period) by 4% in FY25 (total 4,989 enrollments)

Data Source:
Department of Social and Human Services (DSHS), RDA

Description of Data:
Includes all people who have received supported employment services.

Data issues/caveats that affect outcome measures:
No issues are currently foreseen that will impact the outcome of this measure.

Indicator #: 2
Indicator: Increase number of people receiving supportive housing

Baseline Measurement: FY2022 – 7,353 enrollments in supportive housing

First-year target/outcome measurement: Increase average number of people receiving supportive housing services per month (over 12-month period) by 4% in FY24 (total 7,647 enrollments)

Second-year target/outcome measurement: Increase average number of people receiving supportive housing services per month (over 12-month period) by 4% in FY25 (total 7,952 enrollments)

Data Source:
Department of Social and Human Services (DSHS), RDA

Description of Data:
Includes all people who have received supported housing services.

Data issues/caveats that affect outcome measures:
No issues are currently foreseen the will impact this outcome measure.

Priority #: 9

Priority Area: Increase the number of adults receiving outpatient substance use disorder treatment, including those prescribed medications for opioid use disorder (MOUD)
Priority Type: Substance Use Treatment (SUT)
Population(s): Pregnant Women and Women with Dependent Children (PWWDC), Pregnant and Parenting individuals (PP), Persons who Inject Drugs (PWID), Tuberculosis (TB)

Goal of the priority area:
Increase the number of adults receiving outpatient SUD treatment including adults who receive medications for the treatment of opioid use disorder (e.g. Methadone, Buprenorphine, and/or Naltrexone).

Objective:

- Require the Behavioral Health – Administrative Services Organizations (BH-ASOs) to improve and enhance available SUD outpatient services to adults.

Strategies to attain the objective:

- Explore new mechanisms and protocols for case management and continue using Performance Based Contracts to increase the number of adults receiving outpatient SUD and MOUD services.

Annual Performance Indicators to Measure Goal Success

Indicator #: 1
Indicator: Increase outpatient SUD and access to Medications for Opioid Use Disorder (MOUD) for adults in need of SUD treatment

Baseline Measurement: SFY22: 41,825; SFY 2020 Percent of Medicaid enrollees with OUD accessing Medications for Opioid Use Disorder: All MOUD 39.2%, Buprenorphine/Bup-Naloxone 24.5%, Methadone 14.3%, Naltrexone 1.5%

First-year target/outcome measurement: Increase the number of adults with SUD receiving treatment in SFY24 to 47,875. Percent of Medicaid enrollees with OUD accessing Medications for Opioid Use Disorder: All MOUD 45%, Buprenorphine/Bup-Naloxone 27%, Methadone 16%, Naltrexone 2%

Second-year target/outcome measurement: Increase the number of adults with SUD receiving treatment in SFY25 to 48,888. Percent of Medicaid enrollees with OUD accessing Medications for Opioid Use Disorder: All MOUD 45%, Buprenorphine/Bup-Naloxone 27%, Methadone 16%, Naltrexone 2%

Data Source:
The number of adults receiving SUD outpatient services and MOUD is tracked using the Behavioral Health Data System (BHDS).

Description of Data:
Fiscal Year 2020 is an unduplicated count of adults (persons 18 years of age and older) served in publicly funded SUD outpatient treatment and/or receiving MOUD between July 1, 2019 and June 30, 2020.

Data issues/caveats that affect outcome measures:
With the combination of behavioral health services coverage, we are experiencing data reporting challenges due to the way data was collected previously.

Priority #: 10

Priority Area: Pregnant and Parenting Individuals
Priority Type: Substance Use Treatment (SUT)
Population(s): Pregnant and Parenting Individuals (PPI)

Goal of the priority area:

Increase the number of Pregnant and Parenting Individuals (PPI) clients receiving case management services

Objective:
Improve the health of pregnant and parenting individuals and their children and help them maintain their recovery.

Strategies to attain the objective:
• Increase access to case management services

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Expand capacity for women and their children to have access to case management services.
Baseline Measurement: SFY 2022, the total contracted number of Pregnant and Parenting Individuals (PPI) clients receiving PCAP case management services was 1,490 (an increase in capacity of 81 service spaces available to individuals).
First-year target/outcome measurement: SFY 2024 - Increase the number of Pregnant and Parenting Individuals (PPI) clients receiving PCAP case management services by 56 individuals served, totaling to a maximum contracted capacity of 1,546 service spaces available to individuals statewide.
Second-year target/outcome measurement: SFY 2025 - Maintain the number of Pregnant and Parenting Women (PPW) clients receiving PCAP case management services.

Data Source:
Contracts with PCAP providers.

Description of Data:
The contracts mandate that PCAP providers must submit the number of clients being served: 1) on their monthly invoices in order to be reimbursed, 2) to the University of Washing ADAI for monthly reporting.

Data issues/caveats that affect outcome measures:

- If funding is reduced for any reason, the number of sites/clients served may decrease.

Priority #: 11

Priority Area: Tuberculosis Screening

Priority Type: Substance Use Treatment (SUT), Mental Health Services (MHS)
Population(s): Tuberculosis (TB)

Goal of the priority area:
Provide Tuberculosis screening at all SUD outpatient and residential provider agencies within their provider networks.

Objective:
- Ensure TB screening is provided for all SUD treatment services.

Strategies to attain the objective:
- Review TB screening plans with the BH-ASOs for each of the state's ten regions during contract amendment cycles.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Provide TB screening and education at all SUD outpatient and residential provider agencies within their provider networks.

Baseline Measurement: As of July 1, 2022, Tuberculosis screening and education is a continued required element in the BH-ASO contract for SUD treatment services.

First-year target/outcome measurement: For SFY 2024, ensure TB screening plans continue to be in contract with each of the ten BH-ASOs.

Second-year target/outcome measurement: For SFY 2025, review TB screening plans prior to the BH-ASO amendment and update as needed to ensure screenings and education services are being provided during SUD treatment services.

Data Source: Health Care Authority/BH-ASO Contracts

Description of Data:
The contracts between the Health Care Authority and the BH-ASOs will be maintained to include this language.

Data issues/caveats that affect outcome measures:
None

Priority #: 12

Priority Area: Workforce Innovation
Priority Type: Substance Use Prevention (SUP), Substance Use Treatment (SUT), Substance Use Recovery (SUR), Mental Health Services (MHS), Early Serious Mental Illness (ESMI), Behavioral Health Crisis Services (BHCS)
Population(s): Serious Mental Illness (SMI), Serious Emotional Disturbance (SED), Early Serious Mental Illness (ESMI), Behavioral Health Crisis Services (BHCS), Pregnant Women and Women with Dependent Children (PWWDC), Pregnant and Parenting individuals (PP), Persons who Inject Drugs (PWID), Tuberculosis (TB)

Goal of the priority area:
Workforce education and training supports

Objective:
- To support awareness of and interest in behavioral health careers and ongoing training and education.

Strategies to attain the objective:
- Behavioral health recruitment and retention campaign
  - Engaging audiences through passion, opportunity and connection to what they love about behavioral health career opportunities through an outreach and education campaign to the residents of Washington state. ~~www.startyourpath.org~~
  - Including toolkits and resources for supervisors and provider education.
- Continuing education and trainings for workforce
  - Peer certification trainings
  - Peer wellness coach and train the trainer trainings
  - Wellness recovery action plan trainings and facilitator training
  - Peer crisis certification trainings
  - Envisioning family leadership academy
  - Relevant conferences with continuing education credits
  - Wraparound with intensive services SMI/SED workforce development trainings
  - WAADAC Workforce Summit
  - First Episode Psychosis community education for early intervention
  - First Episode Psychosis new journeys learning event
  - Designated Crisis Responder trainings
  - Prevention fellowship and apprenticeship programs
  - Prevention Training Series:
    - Community Anti-Drug Coalitions of America Boot Camp
    - Substance Abuse Prevention Skills Training
    - Community Prevention Wellness Initiative Training Series
    - Health Equity Prevention Services and Training
  - Tele-behavioral health training series

- Training Behavioral Health Agency staff to effectively treat mental health conditions for youth that are Autism Spectrum Disorder and Intellectual and Developmental Disabilities
-

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Monitor campaign landing page traffic, stakeholder feedback, continuing education and training review for content relevance.

Baseline Measurement:
StartYourPath.org Campaign state fiscal year 2023 workforce campaign there were:
- 19,252,281 Impressions
- 1,758,716 Views
- 191,494 Landing page sessions

First-year target/outcome measurement: Maintain or increase baseline metrics
- 19,252,281 Impressions
- 1,758,716 Views
- 191,494 Landing page sessions

Second-year target/outcome measurement: Maintain or increase baseline metrics
- 19,252,281 Impressions
- 1,758,716 Views
- 191,494 Landing page sessions

Data Source:
Contractor Reporting

Description of Data:
Campaign impressions and training / conference review metrics

Data issues/caveats that affect outcome measures:
None

Priority 13

Priority Area: Increasing access to Behavioral Health Crisis Services (BHCS) through expansion of voluntary mobile crisis services.
Priority Type: Behavioral Health Crisis Services (BHCS), Substance Use Treatment (SUT), Substance Use Recovery (SUR), Mental Health Services (MHS)
Population(s): Serious Mental Illness (SMI), Serious Emotional Disturbances (SED), Behavioral Health Crisis Services (BHCS), Pregnant Women and Women with Dependent Children (PWWDC), Pregnant and Parenting individuals (PP), Persons who Inject Drugs (PWID), Tuberculosis (TB)

Goal of the priority area: Increase access to BHCS and improve outcomes for people receiving these services by expanding mobile crisis services. With the designation and routing of 988, the State of Washington has been implementing SAMHSA's best practice toolkit with a focus on expanding mobile crisis services. This started in 2021 with new legislation and funding for more mobile crisis services. These efforts are ongoing.

Objective:

- Expand mobile crisis services
- Reduce unnecessary use of first responders and emergency departments
- Improve outcomes for those in crisis by providing ongoing stabilization services

Strategies to attain the objective:

- Increase the number of mobile crisis teams
- Increase access to stabilization services by improving capacity of teams to provide these services.

Annual Performance Indicators to Measure Goal Success

Indicator #: 1
Indicator: Maintain and increase number of mobile crisis providers in the state.

Baseline Measurement: 42 teams statewide

First-year target/outcome measurement: Maintain current statewide number of mobile crisis providers at 42 teams.

Second-year target/outcome measurement: Increase the statewide number of mobile crisis providers by at least 6 new teams, for a total of 48 teams statewide.

Data Source: Report on current number of teams and FTE from BH-ASOs

Description of Data: Data is collected from BH-ASOs through surveys of providers with mobile crisis teams about current FTEs, number of openings, and basic coverage ability.

Data issues/caveats that affect outcome measures: Workforce challenges, limited ability to predict demand for new and emerging services, and data collection issues.

Priority Area: Increase the number of adults receiving opioid use disorder treatment, support during recovery from OUD, and tools necessary to reduce deaths resulting from opioid overdose and poisoning.
Priority Type: Substance Use Treatment (SUT), Substance Use Recovery (SUR)
Population(s): Pregnant Women and Women with Dependent Children (PWWDC), Pregnant and Parenting Individuals (PP), Persons who Inject Drugs (PWID)

Goal of the priority area: Increase accessibility of treatment for individuals experiencing opioid use disorder; support individuals in recovery from opioid use disorder; reduce the harms associated with opioid use and misuse.
Objective:

- Increase the use of naloxone to prevent deaths from opioid overdose.
- Increase opportunities for incarcerated individuals to receive OUD assessment, OUD medication, sustained treatment throughout incarceration, and connection to continue treatment upon release or transfer.
- Provide behavioral health services to individuals who are at risk of arrest or have been involved in the criminal legal system due to unmet behavioral health needs.
- OUD treatment penetration.

Strategies to attain the objective:

- Partner with syringe exchange programs, local agencies, physical health settings, and emergency services to equip lay responders and professionals with overdose response training and naloxone.
- Partner with the University of Washington Addiction, Drug and Alcohol Institute (UW ADAI) to provide training and technical assistance to participating jails to increase the number of incarcerated individuals assessed for OUD, newly prescribed buprenorphine or naltrexone, or continuing treatment for individuals taking MOUD upon booking.
- Improve communication and coordination with referring partners to increase the number of individuals receiving services from the Recovery Navigator Program (RNP) and Law Enforcement Assisted Diversion (LEAD) program.
- Treatment penetration rates

Annual Performance Indicators to Measure Goal Success

Indicator #: 1
Indicator: Increase the number of naloxone kits distributed, individuals trained on naloxone administration, and reported overdose reversals with program kits.

Baseline Measurement: WA-PDO grant: Between August 31, 2021 and August 30, 2022, 12,494 naloxone kits were distributed, 2,721 individuals were trained on naloxone administration, and 1,957 overdose reversals using program kits were reported. SABG grant: Between October 21, 2021 and September 30, 2022, 31,020 naloxone kits were distributed, 14,129 individuals were trained on naloxone administration, and 5,599 overdose reversals using program kits were reported.

First-year target/outcome measurement: Increase baseline by 50% to 65,271 Naloxone kits distributed.

Second-year target/outcome measurement: Increase baseline by 75% to 76,149 Naloxone kits distributed.

Data Source: Department of Health, Office of Education and Naloxone Distribution (OEND)

Description of Data: The data includes the number of naloxone kits distributed through OEND with support provided by DOH and HCA. Targets include estimations based on all funding sources, both state and federal.

Data issues/caveats that affect outcome measures: FY 25 targets could be affected, either increased or decreased, based on legislative appropriations in the 2024 Supplemental budget.

Indicator #: 2
Indicator: Increase the number of incarcerated people newly prescribed buprenorphine or naltrexone and the number of incarcerated people continuing treatment who were taking MOUD upon booking.

Baseline Measurement: Estimates for SFY23: 3,030 incarcerated individuals newly prescribed buprenorphine or naltrexone; 880 incarcerated individuals continuing MOUD treatment.

First-year target/outcome measurement: Increase the number of incarcerated individuals newly prescribed buprenorphine or naltrexone in SFY24 to 3,180. Increase the number of incarcerated individuals continuing MOUD treatment after booking to 920.

Second-year target/outcome measurement: Increase the number of incarcerated individuals newly prescribed buprenorphine or naltrexone in SFY24 to 3,260. Increase the number of incarcerated individuals continuing MOUD treatment after booking in SFY24 to 943.

Data Source: Programmatic data collected by 19 MOUD in jail programs throughout the state.

Description of Data: Data collected includes the number of people incarcerated among the 19 programs who are inducted on buprenorphine; and he number of people incarcerated among the 19 programs who were continued on MOUD upon booking.

Data issues/caveats that affect outcome measures: FY 25 targets could increase or decrease based on whether or not funding level are changes in the 2024 Supplemental Budget.

Indicator #: 3

Indicator: Increase the total number of referrals, follow-ups, and outreaches in the Recovery Navigator Program.

Baseline Measurement: SFY22: 4,603 referrals, 213 follow-ups, and 3,697 outreaches.

First-year target/outcome measurement: Increase the total number of referrals into the RNP in SFY24 by 100% to 9,206;
Increase the total number of follow-ups by 100% in SFY2024 to 426; increase the total number of outreaches by 100% in SFY2024 to 7,394

Second-year target/outcome measurement: Maintain the total number of referrals into the RNP in SFY2025 at 9,206
Maintain the total number of follow-ups in SFY2025 at 426
Maintain the total number of outreaches in SFY2025 at 7,394.

Data Source: Recovery Navigators quarterly data submissions.

Description of Data: SFY22 is an unduplicated count of adults referred to, followed up with, or otherwise contacted by Recovery Navigators between July 1, 2021 and June 30, 2022.

Data issues/caveats that affect outcome measures: N/A

Indicator #: 4
Indicator: Increase opioid use disorder treatment penetration rates.

Baseline Measurement: SFY19: 52,471 Medicaid beneficiaries had a treatment need, 55% of whom received treatment.

First-year target/outcome measurement: Increase the percentage of Medicaid beneficiaries receiving needed treatment for OUD in SFY24 to 60%.

Second-year target/outcome measurement: Increase the percentage of Medicaid beneficiaries receiving needed treatment for OUD in SFY25 to 65%.

Data Source: Washington State conducted, retrospective (by year), a cross-sectional analyses of Washington State SUD/OUD administrative data to produce a Current State Assessment of the state of SUD/OUD treatment penetration, among other things. All data were drawn from the Department of Social and Health Service's Integrated Client Database (ICDB). The ICDB contains data from several administrative data systems, including the state's ProviderOne data system that contains Medicaid claims and encounter data.

Description of Data: The population of focus was Medicaid beneficiaries (ages 13-64 years) with behavioral health diagnoses. Medicaid beneficiaries with a non-Medicaid primary health

care coverage (also referred to as third-party liability) and those who are dually enrolled in Medicaid and Medicare were excluded from the analyses, as complete health care utilization information may not be available for these individuals. Analyses were further restricted to individuals who met minimum Medicaid enrollment criteria (11 out of 12 months in the measurement year) to meet eligibility requirements for the treatment penetration rate metrics. Medicaid beneficiaries with a SUD or OUD diagnosis are the primary focus of the Current State Assessment.

Data issues/caveats that affect outcome measures: Current data available only shows FY17 through FY 19. 2019 is the last "non covid" year for which we have data. This analysis is currently being updated with data through FY 2022. This data could reveal unknown changes in treatment penetration that may be caused by the Covid 19 pandemic. This analysis will be available later this year. Once available targets for this indicator may need to be revised.

Environmental Factors and Plan

Access to Care, Integration, and Care Coordination

Across the United States, significant percentages of adults with serious mental illness, children and youth with serious emotional disturbances, and people with substance use disorders do not access needed behavioral health care. States should focus on improving the range and quality of available services and on improving the rate at which individuals who need care access it. States have a number of opportunities to improve access, including improving capacity to identify and address behavioral needs in primary care, increasing outreach and screening in a variety of community settings, building behavioral health workforce and service system capacity, and efforts to improve public awareness around the importance of behavioral health. When considering access to care, states should examine whether people are connected to services, and whether they are receiving the range of needed treatment and supports.

A venue for states to advance access to care is by ensuring that protections afforded by MHPAEA are being adhered to in private and public sector health plans, and that providers and people receiving services are aware of parity protections. SSAs and SMHAs can partner with their state departments of insurance and Medicaid agencies to support parity enforcement efforts and to boost awareness around parity protections within the behavioral health field. The following resources may be helpful: ~~https://store.samhsa.gov/product/essential-aspects-of-parity-training-tool-for-policymakers/pep21-05-00-001; https://store.samhsa.gov/product/Approaches-in-Implementing-the-Mental-Health-Parity-and-Addiction-Equity-Act-Best-Practices-from-the-States/SMA16-4983~~ The integration of primary and behavioral health care remains a priority across the country to ensure that people receive care that addresses their mental health, substance use, and physical health problems. People with mental illness and/or substance use disorders are likely to die earlier than those who do not

have these conditions.[1]Ensuring access to physical and behavioral health care is important to address the physical health disparities they experience and to ensure that they receive needed behavioral health care. States should support integrated care delivery in specialty behavioral health care settings as well as primary care settings. States have a number of options to finance the integration of primary and behavioral health care, including programs supported through Medicaid managed care, Medicaid health homes, specialized plans for individuals who are dually eligible for Medicaid and Medicare, and prioritized initiatives through the mental health and substance use block grants or general funds. States may also work to advance specific models shown to improve care in primary care settings, including Primary Care Medical Homes; the Coordinated Care Model; and Screening, Brief Intervention, and Referral to Treatment.

Navigating behavioral health, physical health, and other support systems is complicated and many individuals and families require care coordination to ensure that they receive necessary supports in and efficient and effective manner. States should develop systems that vary the intensity of care coordination support based on the severity seriousness and complexity of individual need. States also need to consider different models of care coordination for different groups, such as High-Fidelity Wraparound and Systems of Care when working with children, youth, and families; providing Assertive Community Treatment to people with serious mental illness who are at a high risk of institutional placement; and connecting people in recovery from substance use disorders with a range of recovery supports. States should also provide the care coordination necessary to connect people with mental and substance use disorders to needed supports in areas like education, employment, and housing.

- *[1]Druss, B. G., Zhao, L., Von Esenwein, S., Morrato, E. H., & Marcus, S. C. (2011). Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Medical care, 599-604.Avaiable at: **https://journals.lww.com/lww-medicalcare/Fulltext/2011/06000/Understanding_Excess_Mortality_in_Persons_With.11.aspx***

Please respond to the following items in order to provide a description of the healthcare system access to care, integration and care coordination activities:

1. Describe your state's efforts to improve access to care for mental disorders, substance use disorders, and co-occurring disorders, including detail on efforts to increase access to services for:

a) Adults with serious mental illness

Since 2016, the state has been integrating the purchasing of physical and behavioral health services through its Managed Care (Apple Health) Plans. Under integrated managed care, services are coordinated through a single health plan, including physical health, mental health, and substance use disorder (SUD) treatment. Now, the state is focusing on clinical integration and implementing a statewide, standardized assessment that will also serve as an integration roadmap for practices and providers. This will further:

- Support whole-person care by creating one system for physical and behavioral health care, rather than having separate systems.

- Improve provider communication and reduce unnecessary duplication of services.
- Expand access to behavioral health to include mental health and SUD treatment.
- Link clients with critical community services, such as housing and employment support.

The standardized assessment is called the **WA-ICA**, which will help providers/practices track, measure, and advance their efforts in advancing clinical integration in Washington State. It will also establish a common language and approach to integration and help stakeholders identify where funding and policy support is needed.

Initially the assessment is voluntary but will ultimately be required for outpatient primary care and behavioral health providers who provide services to Apple Health enrollees. The assessment will assist practices with understanding their level of integration and help identify next steps along the integration continuum. Practices will be eligible for coaching support and technical assistance to help them make progress on integration.

b) Pregnant women with substance use disorders

Washington Medicaid Managed Care Plans are each responsible for care coordination and connection to services for their members.

Additionally, Washington is working to create options for Pregnant and Parenting Individuals through several pathways to build upon our existing PPW treatment network. Our legislature funded an additional Pregnant and Parenting Residential Substance Use Disorder Residential Treatment Facility with direction to build it within the framework of family preservation
The work is underway with our SUD providers, our Medicaid office, Dept. Of Health, and Dept. Of Child Welfare to create a shared understanding of what 'Family Preservation' is and what it will take to support providers standing up a Substance Use Disorder Treatment Facility using a Family Preservation Model. Washington is also exploring and supporting what's known as a 'Rising Strong' model that will be modeled from a housing foundation and have services and supports of a residential model available to Pregnant Parenting Individuals to support the ongoing safe and stable housing need.

We anticipate using the Family Preservation Model work funded for the Substance Use Disorder Residential Treatment Facility, to inform shifts throughout the continuum of care for Pregnant and Parenting Individuals and their Dependent Children, attending treatment with their Parent(s). MOUD and support for other medical based supports are also core elements of this work.

c) Women with Substance Use Disorders who have Dependent Children

Washington is working to create options for Pregnant and Parenting Individuals through several pathways to build upon our existing PPW treatment network. Our legislature funded an additional Pregnant and Parenting Substance Use Disorder Residential Treatment Facility with direction to build it within the framework of family preservation

The work is underway with our SUD providers, our Medicaid office, Dept. Of Health, and Dept. Of Child Welfare to create a shared understanding of what 'Family Preservation' is and what it will take to support providers standing up a Substance Use Disorder Treatment Facility using a Family Preservation Model. Washington is also exploring and supporting what's known as a 'Rising Strong' model that will be modeled from a housing foundation and have services and supports of a residential model available to Pregnant Parenting Individuals to support the ongoing safe and stable housing need.

These models are both exploring the needs of families working toward and participation in dependency and/ or reunification.

d) Persons who inject drugs

Syringe services programs (SSPs) are well known for their success in engaging people who use drugs (PWUD), especially those who inject or smoke opioids and/or stimulants, by providing safer drug use equipment to prevent infection and disease transmission. Most SSPs also provide additional health services including onsite testing (and, in some cases, treatment) for HIV and viral hepatitis, vaccinations, reproductive health resources, and referrals or direct linkage to health and social services, including substance use treatment. Most recently, many SSPs now also offer onsite access to buprenorphine to treat opioid use disorder (OUD). Other harm reduction programs with similar services include day service programs for those who are unhoused and community health clinics with an overt harm reduction mission.

In 2019, Washington State Health Care Authority began a contract with University of Washington- Addictions, Drug & Alcohol Institute (ADAI) to support the community-Based "Meds First" program, now called the Nurse Care Manager program, to provide onsite, low-barrier access to buprenorphine in partnership with six harm reduction programs (HRPs) across Washington State. A key component of the service model was the addition of care navigation to support client engagement and retention in OUD treatment. While care navigation is commonly used in health care, substance use treatment, housing, and mental health settings, it is rarely funded and available at Syring SSPs and other HRPs.

The Community Meds First model of care is defined by these essential characteristics:

- Service provided within or adjacent to syringe services programs/harm reduction programs.
- Care team with a prescriber, nurse care manager, and at least one care navigator.
- Walk-in, same-day access to buprenorphine.
- Six months of follow-up care as a bridge to longer-term OUD treatment, onsite or in the community.
- Ongoing substance use seen as an opportunity for further engagement, not as treatment failure or reason for discharge.
- Shared decision making for medications for opioid use disorder.
- Counseling offered but not mandated.

Intravenous drug users are also priority populations for the Nurse Care Manager project, which is a state-funded project which aims to increase access to medication for opioid use disorder services. The only eligibility requirements for the individual to receive care through this project they must meet the Diagnostic and Statistical Manual of Mental Disorders (DSM 5) diagnostic criteria for opioid use disorder (OUD) and meet state and federal eligibility requirements for admission.

e) Persons with substance use disorders who have, or are at risk for, HIV or TB

Washington State Rules have various requirements for behavioral health agencies (BHA) to document screening and referrals related to infectious disease. Personnel who work at BHAs, that provide substance use disorder (SUD) services, require staff orientation and annual training related to prevention and control of communicable disease, bloodborne pathogens, and tuberculosis. Similar training is required for the multi-disciplinary staff at Withdrawal Management facilities, where training for individuals providing direct care are required to complete training on infectious diseases, to include hepatitis and tuberculosis. In addition, Washington State Opioid Treatment Programs (OTP) are required, through Washington Administrative Code, to provide educational materials covering infectious diseases, sexually transmitted infections, and tuberculosis to everyone admitted.

Since 2020, the State Opioid Response Opioid Treatment Networks and Hub & Spokes provide HIV and viral Hepatitis screening, referrals and/or treatment to individuals with Opioid Use Disorder (OUD) or co-occurring OUD. Of the individuals provided medications for opioid use disorder in 2022, 8,057 were provided testing and referrals for HIV treatment and 6,708 were provided testing and referrals for viral Hepatitis. These programs work within their organizations, subcontracted or community partners to provide these services. They are also encouraged to coordinate and collaborate with the Ryan White HIV/AIDS Program (RWHAP) which provides a comprehensive system of care including medical care and support services for people living HIV who are uninsured or underinsured.

f) Persons with substance use disorders in the justice system

The Criminal Justice Treatment Account is a state proviso-funded resource that distributes funding to BHASOs and counties throughout the State of WA to pay for substance use treatment for participants of therapeutic courts (drug, juvenile, etc.) with the intention of supporting recovery in place of simply relying on incarceration to address substance use of concern. To be eligible, one simply needs to be charged with a crime and present with substance use that does or has the potential to lead to a state wherein it would be a diagnosable disorder. Funds support administrative costs, innovative/best practice implementation, treatment options spanning a comprehensive spectrum in terms of intensity, and a flexible variety of recovery supports (housing, clothing, childcare, transportation, education, job training, etc.).

Since 2018, the participating State Opioid Response Opioid Treatment Network (OTN) jails have been responsible for inducting individuals with Opioid Use Disorder onto MOUD, screening and referring for re-entry services, eliminating barriers to recovery resources upon release, and providing overdose prevention education and naloxone kits. The OTN jails focus on establishing strong relationships with community and network partners to ensure individual recovery success. There are currently four in Washington state located at the Benton County Jail, Franklin County Jail, Kitsap County Jail, and SCORE Jail.

According to a recent survey of Washington state jails, approximately sixty percent of those incarcerated have known or suspected substance use disorders (SUD) including opioid use disorder (OUD) at intake. The high prevalence of OUD among incarcerated individuals can lead to increased risk of early death, hepatitis C and HIV. Untreated OUD perpetuates the cycle of incarceration, making it highly likely that individuals who use opioids will circulate back through the correctional system. The MOUD in jails program provides incarcerated individuals the opportunity for an OUD assessment, OUD medication, sustained treatment throughout incarceration and connection to continue treatment upon release or transfer. Overall benefits may include reduction in morbidity and mortality due to overdose, reduced re-offenses, reduced complications during withdrawal, improved jail staff safety, cost savings, reduced transfers to emergency departments, custodial costs, and overall improved relationships. The MOUD in Jails Program provides the following:

- Opioid Use Disorder Screening, Clinical Opioid Withdrawal Scale (COWS)
- MOUD continuation or induction: offer all three FDA approved medications; buprenorphine, naltrexone and methadone when an OTP is available.
- Screen for and support acute withdrawal
- Reentry coordination/transition Services
- Naloxone and release kits
- Staffing: medical, case management, SUDP, peer specialists, and correctional officers

The MOUD in jails program, Criminal Justice Treatment Account, and the State Opioid Response, Opioid Treatment Network programs in Jail contribute to the Washington State Opioid and Overdose Response Plan under goal 2 by expanding low-barrier access to MOUD in state jails (2.2.1), providing alternative funding to address the Medicaid gap for incarcerated individuals (2.2.10), and expanding access to and utilization of behavioral health services, including opioid use disorder medications in the criminal legal system, and improve effectiveness and coordination of jail re-entry services across the state (strategy 2.4).

g) Persons using substances who are at risk for overdose or suicide

The Washington State Health Care Authority (HCA) has been working with the Washington State Department of Health (DOH) since 2018 contracting various funding sources received by HCA to DOH.

Initially HCA was instructed by the Washington State Legislature to use funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) Substance Abuse Block Grant (SABG) to fund naloxone distribution across the state and was the inception of the Overdose Education and Naloxone Distribution (OEND) section at DOH. DOH provides overdose response training and distributing naloxone through syringe exchange programs, local agencies, physical health settings, and emergency services. Activities engage professional, first responders, local and regional stakeholders, and health care providers to reduce overdose risk and deaths among people who use heroin and prescription opioids. Per the Naloxone Distribution Plan, DOH has taken the lead on naloxone distribution and overdose response training. This program funded by SAMHSA SABG is one of the strategies developed by the State Opioid Overdose Response Plan under the authority of Executive Order 16-109 with the purpose of preventing opioid overdose and deaths from opioid overdose, and building local infrastructure to plan, implement, evaluate, and fund overdose prevention efforts in the long-term. The objectives are:

1. Equip lay responders and professionals with overdose response training/naloxone through access at local agencies/ entities;
2. Educate health care providers, local agencies, syringe exchange programs, and emergency services on opioid guidelines, patient overdose education, opioid use disorders, and naloxone distribution; and
3. Build and harmonize data infrastructures to inform resource allocation, maintain overdose surveillance, and measure outcomes;
4. Make sure there is not overlap of naloxone distribution between this program and the WA-PDO program; and
5. Work closely with HCA DBHR to develop a sustainability plan, to include funding, in preparation for the WA-PDO grant expiring in August 2026.

Secondly, HCA contracts funding from the SAMHSA Washington State Project to Prevent Prescription Drug/Opioid Overdose (WA-PDO). This funding began on August 31, 2021, and is part of a five-year grant specific to overdose prevention. The WA-PDO is a statewide network of organizations mobilizing communities, providing overdose response training, and distributing naloxone through syringe exchange programs in five high-need areas (HNAs). Activities engage professional, first responders, pharmacies, local and regional stakeholders, health care providers, and lay responders to reduce overdose risk and deaths among people who use heroin and prescription opioids. The purpose is preventing opioid overdose and deaths from opioid overdose, and building local infrastructure to plan, implement, evaluate, and fund overdose prevention efforts in the long-term. The objectives are:

1. Develop overdose prevention strategic plans in five HNAs;
2. Equip law enforcement with overdose response training/naloxone;
3. Equip lay responders (LR) with overdose response training/naloxone;
4. Increase naloxone dispensed by pharmacists each year;
5. Educate health care providers on opioid guidelines, patient overdose education, and naloxone and opioid use disorders;

6. Develop new models of substance use treatment linkage and care coordination in five HNAs;
7. Facilitate coordination in five HNAs among local and regional stakeholders and with state agencies;
8. Fuild and harmonize data infrastructures to inform resource allocation, maintain overdose surveillance, and measure outcomes; and
9. Create knowledge translation infrastructure to disseminate emerging data, best practices, training, and technical assistance.

HCA is also evaluating options for creating and maintaining a bulk purchasing and distribution program for opioid reversal medications as directed by Second Substitute Senate Bill (2SSB) 5195 (2021). Given the state of the opioid epidemic, Washington State needs new strategies to address increasing drug-caused deaths involving opioids. This bill directs state agencies to act in improving access to opioid reversal medications, including establishing a bulk purchasing and distribution program. To create this program, HCA has identified external stakeholders who can help provide input and perspective to HCA about how to successfully create and maintain such an initiative. HCA has contracted with the Center for Evidence-based Policy (CEbP) at Oregon Health and Science University (OHSU) to continue exploring policy and program considerations for HCA to evaluate. HCA is also hiring staff to help support the management of this program and to leverage data from the Washington State All-Payer Claims Database (WA-APCD) to better understand the landscape of naloxone use in Washington.

h) Other adults with substance use disorders

Washington State Health Care Authority weaves various funding streams to ensure a full continuum of substance use disorder services are available for the adult population. Many of these programs are low-barrier and focus on initial engagement that focuses on principles of harm reduction and medication-first ideology. The SUD outpatient and treatment services are designed to meet the needs of the individual. Level of care is established using the American Society of Addiction Medicine (ASAM) standards and varies depending on the severity of the disorder and the needs of the individual. Addressing underlying reasons for problematic substance use and creating relapse prevention strategies remain the primary foci of SUD counseling.

The continuum of care includes activities designed to engage and connect individuals to recovery services, such as outreach, screening in primary health care or other nonbehavioral health treatment settings, and case management services. One example of a low-barrier program, which engages individuals along the continuum of care, is our State Hub and Spoke (H&S) project.

The H&S model was designed to create a coordinated, systemic response to the complex issues of opioid addiction among Medicaid and low-income populations, focusing specifically on medication for individuals with Opioid Use Disorder (OUD). The hub sites are the primary organization of the project and recipient of funding for the development of the overall project

development. The hub sites identify, collaborate, and subcontract with spoke sites to provide integrated care, regardless of how participants enter the system.

Spokes are facilities that provide OUD treatment, behavioral health treatment and/or primary healthcare services, syringe exchange programs, criminal justice programs including jails, and/or wraparound services and referrals. While there has been less movement of patients across the hub and spokes than initially anticipated, the spokes are used as referral sources as needed. Each H&S network is staffed with nurse care managers and care navigators to reduce barriers for individuals seeking services and to help prescribing practitioners manage increases in their practice.

Strategies and interventions will include Evidence Based/Evidence Informed Practices. Project goals are to increase the number of patients receiving medication for opioid use disorder by increasing capacity in a variety of settings and to enhance the integrated care that patients receive, improve retention rates for enrollees, decrease drug and alcohol use, decrease overdoses, and reduce adverse outcomes related to OUD.

i) Children and youth with serious emotional disturbances or substance use disorders

WA legislature invested in standing up youth behavioral health navigators - also known as Kids Mental Health WA which funds regions to stand up region wide networks to work towards their regions needs for the population including mental health, SUD and co-occurring ASD/IDD and Mental health. The regional teams then hold multidisciplinary meetings with specific youth and families seeking support in accessing care that meets their needs, pulling in partners from the network to meet the need, or support the youth and family until access becomes available. Legislature funded a rollout from 2023-2025 - and all regions across the state are participating in the learning collaboratives to support newer regions learning from regions that have stood up networks and multi-disciplinary teams.

Additionally, Washington state continues to build capacity in our Wraparound with Intensive Services (WISe) program through partnerships with youth peer organizations, cultural adaptations in partnership with our Tribes and BIPOC community leaders, and piloting two sites where Applied Behavioral Analysis (ABA) is the intensive service.

Lastly, Washington is deeply invested in expanding access to our Specialty care program for First Episode Psychosis - New Journeys through inclusion in our Medicaid rates toward the goals set by our legislature to have access across Washington based on prevalence and population.

j) Individuals with co-occurring mental and substance use disorders

All of the programs that are currently coordinated out of HCA-Division of Behavioral Health and Recovery assume and understand that this population experiences a high rate of co-occurring mental and physical health disorders, along with substance use disorders. Many of the state and federally funded programs include multi-disciplinary teams which consist of licensed

mental health professionals, peers, medical providers, and substance use disorder professionals. An example of one of these programs is the Homeless Outreach Stabilization Transition Project. The Homeless Outreach Stabilization and Transition (HOST) program provides outreach-based treatment services to individuals with serious behavioral health challenges including substance use disorder (SUD). Multidisciplinary teams can provide SUD, medical, rehabilitative, and peer services in the field to individuals who lack consistent access to these vital services. HOST eligibility means that an individual has a behavioral health challenge, which can include SUD with or without co-occurring mental illness, that is untreated, under-treated or undiagnosed, and is experiencing literal or chronic homelessness. HOST eligible individuals will also be experiencing behavioral health symptoms that create a barrier to accessing and receiving conventional behavioral health services and outreach models.

2. Describe your efforts, alone or in partnership with your state's department of insurance and/or Medicaid system, to advance parity enforcement and increase awareness of parity protections among the public and across the behavioral and general health care fields.

The Health Care Authority, the Single State Authority for Substance Use, Mental Health and Medicaid, adheres to the Mental Health Parity and Addiction Equity Act enacted in 2008 requiring MCOs to provide coverage for mental health conditions, including substance use disorders, to be no more restrictive than insurance coverage for other medical conditions. The parity efforts are monitored by an internal HCA workgroup who meet quarterly to increase awareness as needed. MCOs are evaluated for parity compliance within the following domains: Inpatient, in-network, Inpatient, out of network, Outpatient, in network, Outpatient, out-of-network, emergency care, and prescription medications. A comprehensive parity report is generated by the HCA workgroup every three years. The most recent inquiries into the MCOs and workgroup report indicated that there were no current concerns with parity expectations.

3. Describe how the state supports integrated behavioral health and primary health care, including services for individuals with mental disorders, substance use disorders, and co-occurring mental and substance use disorders. Include detail about:

a) Access to behavioral health care facilitated through primary care providers

Over the last several years, key efforts have been underway to support and/or bolster access to behavioral health care in primary care settings, to include:

- Multi-payer Primary Care Transformation Model – In collaboration with the state's purchasers, payers, and primary care provider community, HCA has been working to develop a new primary care transformation model (PCTM) for the state. This work strives to promote and incentivize integrated, whole-person, and team-based care. Develop high-functioning accountable care teams that address the goals and needs of the individual and family by efficiently organizing and coordinating care across the range of health system partners, inclusive of behavioral health. More information can be

found on our website at https://www.hca.wa.gov/about-hca/programs-and-initiatives/value-based-purchasing/multi-payer-primary-care-transformation-model.

- Collaborative Care Model – Legislation was passed in 2017, Senate Bill 5779, that triggered the implementation of the Collaborative Care Model. The Collaborative Care Model (CoCM) is a model of behavioral health integration that enhances "usual" primary care by adding two key services: care management support for clients receiving behavioral health treatment, and regular psychiatric or board-certified addiction medicine consultation with the primary care team, particularly regarding clients whose conditions are not improving. To support the CoCM model, HCA completed a state plan amendment to add this into the Medicaid benefit. Further guidance and support is provided through the physician related services billing guide, which supports primary care providers in implementation and understanding reimbursement for this team-based model and approach. Additionally, at the prompting of stakeholder engagement, HCA expanded reimbursement options by adding health and behavior codes to the billing guides. More information can be found in our billing guide, at https://www.hca.wa.gov/assets/billers-and-providers/Physician-related-services-bg-20230701.pdf.
- Ensuring robust telehealth policies for all disciplines – Even prior to the public health emergency, HCA had a robust telehealth policy. However, since the pandemic, our policies have significantly expanded to ensure payment parity, as well as allowing for audio only services for established clients. These efforts, in concert with the Department of Commerce work around expanding broadband internet connection to rural and frontier regions, has bolstered access options for all of our physical health and behavioral health services across our state.

b) Efforts to improve behavioral health care provided by primary care providers

As stated above, both the work on the Washington Integrated Care Assessment (WA-ICA) tool and the Primary Care Transformation Model strives to help primary care practices increase, strengthen, and improve clinical integration and team-based models. Those that participate in the WA-ICA receive technical assistance, inclusive of education and tools for primary care practices to better address common conditions such as anxiety and depression, as well as guidelines for screening.

The data sharing efforts are also key work to ensure data sharing practices are a supporting bi-directional care. One of the tools that HCA has offered is a toolkit around confidentiality and data sharing (https://www.hca.wa.gov/assets/billers-and-providers/60-0077-washington-confidentiality-toolkit-providers.pdf).

Currently the MCOs are working on a collaborative Performance Improvement Project centering on ending disparities within racial and ethnic groups for children and youth needing mental health treatment services. The MCOs have partnered with several primary care offices to reach out to children and youth who have been identified as needing follow up care to secure referrals for on-going behavioral health treatment services. This project includes

providing care gap reports for identified children/youth, tracking phone call outreach, and referral processes. They are currently collecting data on these pilot projects and will incorporate the information and processes within their quality improvement work moving forward.

c) Efforts to integrate primary care into behavioral health settings

The Washington Integrated Care Assessment work is a significant effort in supporting behavioral health agencies in developing and strengthening clinically integrated models, inclusive of bringing in primary care. The WA-ICA offers a tool specifically tailored for behavioral health agency settings and provides a roadmap along key domains to move the dial towards more integrated care. The tool is structured in a way that embraces organizations at all levels of integration, from beginner level through intermediate to advanced, or more sophisticated levels of integrated care. It is designed as a quality improvement roadmap.

Washington is also embracing the Certified Community Behavioral Health Clinic (CCBHC) model, which focuses on ensuring integrated outpatient services, as well as prevention and crisis stabilization. Currently there are 17 CCBHCs in Washington, with more coming on board. The legislature directed HCA to provide a report at the end of 2024 exploring the development and implementation of a sustainable alternative payment model for comprehensive community services, including CCBHCs. In addition to the analysis work for the report, HCA is moving forward with an implementation plan with a goal that 90% of Washingtonians will be in a county or be within driving distance of a county with a CCBHC. Part of this work will entail working with stakeholders to determine the level of integration of primary care into these settings.

Finally, a state plan amendment was just submitted for the rehabilitative services section of our state plan that strives to de-silo mental health and substance use disorder services sections, as well as broaden the array of allowable provider types to give providers more flexibility in delivering co-occurring and integrated models of care. Pending CMS approval, the amendment will go into effect January 2024. HCA will then look at a phase 2 state plan amendment to determine further changes to the state plan that would bolster and support more integrated models.

4. Describe how the state provides care coordination, including detail about how care coordination is funded and how care coordination models provided by the state vary based on the seriousness and complexity of individual behavioral health needs. Describe care coordination available to:
a) Adults with serious mental illness
b) Adults with substance use disorders
c) Children and youth with serious emotional disturbances or substance use disorders

Within Washington, care coordination is offered as a benefit for individuals receiving Medicaid through a managed care plan. We currently contract with five MCOs who all provide care

coordination to children, youth and adults experiencing serious mental illness, serious emotional disturbances and SUD. Each MCO has created levels of care coordination based on the needs of individuals and level of care coordination need. MCO care coordination funding is included within the per capita rates. Additionally, there are services, such as WISe (Wraparound with Intensive Services) and PACT (Program for Assertive Community Treatment) that contain care coordination as integral components.

5. Describe how the state supports the provision of integrated services and supports for individuals with co-occurring mental and substance use disorders, including screening and assessment for co-occurring disorders and integrated treatment that addresses substance use disorders as well as mental disorders. Please describe how this system differs for youth and adults.

As of January 2020, Washington fully integrated the Medicaid behavioral health and physical health benefit under an integrated managed care structure, allowing the full continuum of physical and behavioral health care to be managed through health plan managed care contracts. These contracts integrate the financing of physical and behavioral health care and include value-based payment to drive innovation and clinical integration at the practice level. The five Managed Care Organizations function as a single payor, accountable for ensuring whole person integrated care, as well as care coordination. As part of the shift to integrated managed care, the Division of Behavioral Health and Recovery moved to the Health Care Authority, to ensure integrated oversight of both behavioral health and physical health services.

In mid-2020, HCA partnered with our Managed Care Organizations and Accountable Communities of Health to identify a new clinical integration assessment tool to better support the advancement of bi-directional physical and behavioral health clinical integration in Washington State. The tool, called the Washington Integrated Care Assessment (WA-ICA), serves as a standard assessment and quality improvement roadmap that can be used by primary care and behavioral health providers. In 2022, this tool was piloted across the state with an initial cohort of providers. HCA is reviewing the results of that initial pilot and is in the process of determining next steps, to include determining the necessary infrastructure and funding resources available to advance this work. Additional information can be found on the website at https://www.hca.wa.gov/about-hca/programs-and-initiatives/advancing-clinical-integration/what-were-working.

Within Washington, care coordination is offered as a benefit for individuals receiving Medicaid through a managed care plan. We currently contract with five MCOs who all provide care coordination to children, youth and adults experiencing serious mental illness, serious emotional disturbances and SUD.

From a data perspective, HCA is supporting the use of the Clinical Data Repository (CDR) as a tool to advance Washington's capabilities to collect, share and use integrated physical and behavioral health information from provider EHR systems. The CDR is a real time database that

consolidates data from a variety of clinical sources to present a unified view of a single patient.

Within the child and youth population in Washington state, young children (birth – age 5) have the highest rates of unmet mental health care needs (HCA, 2022). Research suggests that challenges around reimbursement systems and specialty training are key barriers to access (Perigee Fund, 2021).

In SFY22-23, Washington engaged in several efforts to improve access to care for young children and their families, through specific work around developmentally appropriate mental health assessment and diagnosis, including:

- Revised reimbursement policies to adequately fund assessments best practices, including assessments that take multiple sessions and/or take place in home and community settings (i.e., natural environments). An evaluation of the impact of these reimbursement changes on service delivery will be conducted in SFY24-25.
- Free training in the DC:0-5, the developmentally appropriate diagnostic manual for young children's mental health, which is recommended by both CMS and SAMHSA. Training will continue through SFY24-25.
- Additional tools and resources to support the use of the DC:0-5, including a community-informed DC:0-5 crosswalk, and updated administrative code to allow the use of the DC:0-5 in individual service records. Additional tools and resources will be developed through SFY24-25.

Washington's innovations in this area have been featured in several national publications and conferences, but we know there is still more work to do. Our recent report highlighted the positive impacts of these policy changes, but also areas where challenges remain. In SFY24-25, we will conduct Listening Sessions with providers from each region of the state to better understand challenges and needs, which will inform our ongoing work in this area.

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

None at this time.

Health Disparities

*In accordance with Advancing Racial Equity and Support for Underserved Communities Through the Federal Government (Executive Order 13985), Advancing Equality for Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex Individuals (Executive Order 14075), the **HHS Action Plan to Reduce Racial and Ethnic Health Disparities**[1], **Healthy People, 2030**[2], **National Stakeholder Strategy for Achieving Health Equity**[3], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and M/SUD outcomes among individuals of all cultures, sexual orientations, gender identities, races, and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (e.g., racial, ethnic, limited English speaking, tribal,*

*sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the **Behavioral Health Implementation Guide for the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care** (CLAS)[4].*

Collecting appropriate data are a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status[5]. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations[6]. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBTQI+ populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide M/SUD services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

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

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is and is not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations.

- [1] **https://www.minorityhealth.hhs.gov/assets/pdf/hhs/HHS_Plan_complete.pdf**
- [2] **https://health.gov/healthypeople**
- [3] **https://www.mih.ohio.gov/Portals/0/Documents/CompleteNSS.pdf**
- [4] **https://thinkculturalhealth.hhs.gov/**

- [5] ***https://aspe.hhs.gov/basic-report/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-and-disability-status***
- [6] ***https://www.whitehouse.gov/wp-content/uploads/2017/11/Revisions-to-the-Standards-for-the-Classification-of-Federal-Data-on-Race-and-Ethnicity-October30-1997.pdf***

Please respond to the following items:

1. **Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, sexual orientation, gender identity, and age?**
    a. Race – Yes
    c. Ethnicity – Yes
    d. Gender – Yes
    d. Sexual Orientation – Yes
    e. Gender Identity – No
    f. Age – Yes

2. **Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population?**
    Yes

3. **Does the state have a plan to identify, address and monitor linguistic disparities/language barriers?**
    Yes

4. **Does the state have a workforce-training plan to build the capacity of M/SUD providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations?**
    No

5. **If yes, does this plan include the Culturally and Linguistically Appropriate Services (CLAS) Standards?**
    No

6. **Does the state have a budget item allocated to identifying and remediating disparities in M/SUD care?**
    No
7. **Does the state have any activities related to this section that you would like to highlight?**

Health Care Authority
The Health Care Authority (HCA) has always done equity work because Medicaid is a tool to support underserved populations. However, as of three years ago there was no standardized and unified process, and no dedicated FTE for health equity. In 2021, HCA established the

Health Equity Director position as well as including liaison responsibilities to at least one staff person in each division to connect each division's health equity work across the agency.

By the end of 2021, all of HCA employee's job description included the statement *HCA employees will apply an equity lens to their work, which may include but is not limited to all analyses of core business and processes.* Using an equity lens is critical in our programs or projects and especially when doing legislative reviews. Using that health equity lens helps to ensure that any disparities in BH services are addressed and removed.

Alongside that, a health equity toolkit was created to help staff understand and apply an equity lens to design and evaluate all of our policies, programs and services. This includes identifying and addressing disparities during the legislative session, where we give input on hundreds of bills. Adding this equity lens has shown a difference in how we evaluate and support bills, services and programs.

In 2022, Governor Inslee issued the Pro Equity Anti Racism executive order, aka PEAR, requiring all state agencies to have a plan to become pro-equity and anti-racist. One of our accomplishments was the establishment of the PEAR community advisory team - CAT. This team is comprised of community members, specifically those who have historically be underserved or underrepresented, who advise our internal PEAR team.

The PEAR and PEAR CAT teams identified 4 key areas known as workstreams that HCA has committed to in 2023. They are:

- Community engagement – which is not to be mistaken for stakeholdering. HCA has launched the first community engagement mini guide. This guide provides insight on how to engage communities in all the various work that you do.
- Data equity strategy – HCA believes in data to back the work being done, and for that data to provide the truth on the services we provide, who is not able to receive services, and identify existing barriers that keep them from reaching out for services in their communities.
- Leadership & operation strategy to enhance health equity – HCA wants to ensure there is clear buy-ins from leadership and is reflected through our daily operations.
- Workforce equity - This is not only focusing on our internal HCA workforce, but also looking at Washington State's health care workforce as a whole. We are exploring ways to create a health workforce to serve all of WA, especially for rural and underserved populations.

We also focus on tribal implications to ensure that there is appropriate government to government collaboration.

<u>Division of Behavioral Health and Recovery Services</u>
Diversity, equity, inclusion, belonging (DEIB), and social justice are not just words to the Division of Behavioral Health and Recovery (DBHR). We are striving to become more intentional about

our efforts to embrace the principles of DEIB, health equity, and social justice in the behavioral health field while continuing to break down systemic 'isms that continue to create barriers around treating individuals with behavioral health challenges.

DBHR approached the need for better awareness about cultural awareness, racism, unconscious bias, health equity, inclusion and belonging by launching the DBHR DEIB Advisory Team. This team is attended by staff from all levels and from varying functions. This Advisory team has the responsibility to create a framework of how DBHR will operationalize and embed DEIB core business functions to include recruitment/promotion/retention, strategic planning around DEIB, performance management, and position descriptions. They are also working to building cultural awareness among division staff by instituting a "DEIB 10" moment at monthly all-staff meetings.

DBHR continues to do positive work to address and combat stigma around mental health and substance use disorder (SUD). For example, Recovery Syn-ERG is an outlet for HCA staff to support others who have or still going through their recovery journey; the Prevention Health Equity workgroup has created an infrastructure that stands by, implements, and monitors for CLAS standards; and ensuring DEIB and Health Equity workshops are a part of any HCA/DBHR supported conferences.

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

We will reach out to SAMHSA for TA when needed.

Evidence Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI)

Much of the mental health treatment and recovery service efforts are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among consumers and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention is critical to treating mental illness before it can cause tragic results like serious impairment, unemployment, homelessness, poverty, and suicide. The duration of untreated mental illness, defined as the time interval between the onset of a mental disorder and when an individual gets into treatment, has been a predictor of outcomes across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be viewed as a negative prognostic factor for those who are diagnosed with mental illness. Earlier treatment and interventions not only reduce acute symptoms, but may also improve long-term prognosis.*

SAMHSA's working definition of an Early Serious Mental Illness is "An early serious mental illness or ESMI is a condition that affects an individual regardless of their age and that is a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-5 (APA, 2013). For a significant portion of the time since the onset of the disturbance, the individual has

not achieved or is at risk for not achieving the expected level of interpersonal, academic or occupational functioning. This definition is not intended to include conditions that are attributable to the physiologic effects of a substance use disorder, are attributable to an intellectual/developmental disorder or are attributable to another medical condition. The term ESMI is intended for the initial period of onset."

*States may implement models that have demonstrated efficacy, including the range of services and principles identified by National Institute of Mental Health (NIMH) via its Recovery After an Initial Schizophrenia Episode **(RAISE)** initiative. Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, states should move their system to address the needs of individuals with a first episode of psychosis (FEP). RAISE was a set of NIMH sponsored studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP. The NIMH RAISE studies, as well as similar early intervention programs tested worldwide, consist of multiple evidence-based treatment components used in tandem as part of a Coordinated Specialty Care (CSC) model, and have been shown to improve symptoms, reduce relapse, and lead to better outcomes.*

State shall expend not less than 10 percent of the MHBG amount the State receives for carrying out this section for each fiscal year to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset. In lieu of expending 10 percent of the amount the State receives under this section for a fiscal year as required a state may elect to expend not less than 20 percent of such amount by the end of such succeeding fiscal year.

** MHBG funds cannot be used for primary prevention activities. States cannot use MHBG funds for prodromal symptoms (specific group of symptoms that may precede the onset and diagnosis of a mental illness) and/or those who are not diagnosed with a SMI.*

1. **Please name the model(s) that the state implemented including the number of programs for each model for those with ESMI using MHBG funds.**

Model(s)/EBP(s) for ESMI/FEP	Number of programs
New Journeys- coordinated specialty care model based on Navigate (EBP).	**15**

2. **Please provide the total budget/planned expenditure for ESMI/FEP for FY 24 and FY 25 (only include MHBG funds).**

FY2024	FY2025
$3,891,004	**$3,891,004**

3. **Please describe the status of billing Medicaid or other insurances for ESMI/FEP services? How are components of the model currently being billed? Please explain.**
   New Journeys has used a combination of federal block grant funds, state and local funds, and Medicaid and commercial insurance billing to finance teams since the first pilot site in

2015. Several New Journeys services are difficult to bill public or commercial insurance through traditional fee-for-service methods, including care coordination, community outreach, and specialty screening. Commercial insurance often only covers psychotherapy, medication and medication management, and family therapy, and some providers do not have the infrastructure to seek commercial insurance payments. Currently, these gaps in reimbursement are covered by either state general funds or federal block grant funds.

In July 2022, Washington implemented a team-based rate for Medicaid. Billing through the Medicaid team-based rate is projected to result in reimbursements of $415,584 per team annually, covering an estimated 76% of New Journeys team costs. Washington's implementation of a Medicaid team-based rate will greatly expand the funding available to the New Journeys network. Since launching the team-based rate, New Journeys has been able to transition 7 teams from federal block grant funds.

Additional funds to account for non-Medicaid activities are paid for with state funds through MCO Wrap Contracts. The non-Medicaid components of the model are funded, over and above, the team-based rate to pay for 36% of the team's time to provide non-Medicaid activities required for fidelity. Two slots per team for underinsured participants are funded through BH-ASO contracts. Training, quality improvement and fidelity activities, as well as start-up and case building of new teams are supported through federal block grant funds.

Washington Health Care Authority is currently partnering with Mercer actuarial group to develop an encounter rate for New Journeys teams. The updated financing will help expand Medicaid funding, covering team costs more fully, providing more options and flexibility in billing to support rural and cultural CSC adaptations.

4. **Please provide a description of the programs that the state funds to implement evidence-based practices for those with ESMI/FEP.**
New Journeys is a coordinated specialty are model based on Navigate. The model offers an array of Medicaid and Non-Medicaid funded recovery support interventions for screening and early identification of psychosis. The service array is already included in the State plan and is provided by a multidisciplinary team that offers a coordinated and specialized approach that targets an individual's unique needs and provides more intensive supports compared to regular outpatient treatment. Each New Journeys team is structured using 4.25 FTE's. Each team serves no more than 30 individuals at a given time.

The New Journeys team members include:

- Program Director/Family Education Provider (1.0 FTE)
- Psychiatric Care Provider (0.25
- FTE)
- Individual Resiliency Training (IRT) Clinician (1.0 FTE)
- Supported Employment and Education (SEE) Specialist (1.0 FTE)

- Peer Support Specialist (0.5 FTE)
- Case Manager and/or Registered Nurse Care Manager (0.5 FTE)

Teams may choose to substitute a nurse care manager (~0.2 FTE) for all or part of the case manager FTE count.

These services are intended to be low barrier and generally available in home, school, community, and clinic settings. This treatment also includes a public education and outreach function that is intended to hasten the identification and rapid referral of youth and young adults experiencing symptoms.

5. **Does the state monitor fidelity of the chosen EBP(s)?**
   Yes

   During the start-up and case building phase of starting new sites, New Journeys teams receive technical assistance through monthly Echo Clinics and consultations calls with University of Washington (UW) the SPIRIT Lab training team. After teams are fully established, they will participate in fidelity review processes administered by the UW Training Team. This involves a two-day onsite review, with 2-3 independent reviewers. It will utilize a NAVIGATE-adapted FEPS-FS fidelity tool and multiple data sources:

   - Program data
   - Interviews
   - Chart reviews
   - Direct observation

   The Washington State University (WSU) annual evaluation provides both qualitative and quantitative data analysis to inform program development and collects program specific information pertaining to outreach, outcomes, and individual experiences. This measurement-based care component of the New Journeys model is considered an evidence-based practice that uses standardized measures to guide treatment practice and planning (Lewis et al., 2018). In addition to monitoring outcomes, the New Journeys evaluation also tracks team/client engagement and service delivery.

   New Journeys team members can use the data platform to collect and administer measures to assess progress and clinical outcomes throughout treatment. Benefits to using a measurement-based care approach include:

   - Improvement in individual clinical outcomes
   - The ability to observe changes in outcomes that can be used by teams in treatment planning meetings.
   - Use of objective assessments enhances clinician judgement.
   - Participants can receive feedback about treatment progress in real time.

6. **Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI/FEP?**
   Yes

7. **Explain how programs increase access to essential services and improve client outcomes for those with an ESMI/FEP?**
   Those experiencing ESMI/FEP often present with special issues related to engagement. Use of outpatient mental health services is the lowest in young adulthood. Data suggests that 46% of those who met criteria for SMI do not receive treatment (IOM, 2015, CMHS, 2011; National Survey of Drug Use and Health, 2018). Research indicates youth and young adults benefit from support to navigate transitions from hospitals, jails, crisis situations and independent living. New Journeys often provides these supports during a vital time in someone's life.

   New Journeys provides outreach and intervention for transition-aged youth (>15), young adults and their families when first diagnosed with psychosis. Members of the New Journeys treatment team will travel to the home, school, or elsewhere in the community to provide assessment, screening, and therapy for people affected by first episode psychosis. New Journeys also utilizes family and peer support partners to assist with engagement.

   The first 6 months of the New Journeys model is focused on engagement. The overall goal is early intervention (decreasing the DUP) and minimizing more restrictive interventions such as jail, hospitalizations, or intervening to minimize consequences of untreated symptoms such as eviction, being taken advantage of by others, misdiagnosis, substance use, self-harm. dropping out of school or losing employment.)

8. **Please describe the planned activities for FY 2024 and FY 2025 for your state's ESMI/FEP programs.**
   - Continued expansion of New Journeys teams based on incidence and population needs.
   - Continued development of rural and AI/AN pilot adaptations to address needs of those at risk of being underserved.
   - Launch the New Journeys encounter rate on July 1, 2025.
   - Training and support for the ESMI/FEP behavioral health workforce
   - Pilot work to expand diagnostic criteria to include affective psychosis in 2025.

9. **Please list the diagnostic categories identified for your state's ESMI/FEP programs.**
   Primary diagnosis of one of the following:
   - Schizophrenia
   - Schizoaffective disorder
   - Schizophreniform disorder
   - Brief Psychotic disorder
   - Delusional disorder
   - Other specified Psychotic disorder

10. **What is the estimated incidence of individuals with a first episode psychosis in the state?**
    In 2021 Research Data and Analysis (RDA), estimated that more than 2,000 youth and young adults in Washington experienced a first episode. This is a low estimate as it only accounts for individuals receiving Medicaid or Medicare. Thinking about these numbers differently, would equate to 235 individuals per 100,000 Medicaid Enrollees.

    These numbers are based on the most recent census data available and population-based incidence rates and validated by retrospective analysis of administrative data by the Washington State Department of Social and Health Services Research and Data Analysis Division (RDA).

11. **What is the state's plan to outreach and engage those with a first episode psychosis who need support from the public mental health system?**
    A primary goal of the state's initiative to support early identification and treatment of first episode psychosis and psychosis risk states is to accurately identify youth and young adults earlier in the course of psychotic illness. Doing so unequivocally supports engagement in coordinated specialty care, reduces the Duration of Untreated Psychosis, and can prevent inpatient hospitalizations. New Journeys includes a local public education and outreach function that is intended to hasten the identification and rapid referral of youth and young adults experiencing symptoms.

    The Central Assessment of Psychosis Service (CAPS) Expansion projects seeks to create a statewide public health campaign to raise awareness of psychosis risk states and development toward professional tele-consultation concerning new-onset psychosis and psychosis risk.

    CAPS supports crisis intervention work by providing a diagnostic and referral service during the workforce shortage where there is currently pressure on the front door of the system of care and lack of staff to perform this function. This service would support front door access decreasing the need for crisis interventions. A stage-wise expansion, executed in collaboration with Health Care Authority; New Journeys Network; Washington State Center of Excellence for Early Psychosis; New Journeys evaluation partner, Washington State University; and University of Washington Medicine.

    The New Journeys Virtual Gathering is a two-day virtual event focused on Early Identification and Treatment of First Episode Psychosis and marketed across networks throughout Washington State. The event is organized in collaboration Health Care Authority and representatives of the New Journeys Network of clinicians and trainers from all over the state. The event aimed to provide attendees with education, resources, best practices, and hopeful outlooks for supporting and identifying individuals experiencing first episode psychosis.

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

Public education and anti-stigma for FEP
Autism and FEP
TA for the intersection of financing with CSC and CCBHC's

Person Centered Planning

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers where appropriate in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning is a process through which individuals develop their plan of service. The PCP may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP team may include family members, legal guardians, friends, caregivers and others that the person or his/her representative wishes to include. The PCP should involve the person receiving services and supports to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person's strengths, goals, preferences, needs and desired outcome. The role of state and agency workers (for example, options counselors, support brokers, social workers, peer support workers, and others) in the PCP process is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs and provide support during planning. The person's goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, education, family relationships, and treatments are part of a written plan that is consistent with the person's needs and desires.

In addition to adopting PCP at the service level, for PCP to be fully implemented it is important for states to develop systems which incorporate the concepts throughout all levels of the mental health network. Resources for assessing and developing PCP systems can be found at the National Center on Advancing Person-Centered Practices and Systems .~~*https://ncapps.acl.gov/home.html*~~ *with a systems assessment at* ~~*https://ncapps.acl.gov/docs/NCAPPS_SelfAssessment_201030.pdf*~~

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1. Does your state have policies related to person centered planning?
Yes

2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.
N/A

3. Describe how the state engages consumers and their caregivers in making health care decisions and enhance communication.
The Program of Assertive Community Treatment (PACT), the First Episode Psychosis New Journeys program, and the Wraparound with Intensive Services (WISe) models define a specific process for treatment planning that are very inclusive of the individuals and their family or others identified by the individual as part of their treatment team. These are person-centered explorations of strengths and challenges across multiple life domains. Fidelity monitoring specifically looks for inclusion of natural supports and PACT fidelity monitoring ensures that all members of PACT teams receive person centered planning training.

In addition to those individuals receiving PACT, New Journeys, and WISe services, all individuals receiving outpatient mental health services are engaged in the development of an individualized service plan. Washington Administrative Code WAC 246-341-0620directs outpatient mental health providers to develop individualized treatment plans that are "consumer-driven, strengths-based, and meet the individual's unique mental health needs". Further, these plans must identify services mutually agreed upon by the individual and provider. Washington State promotes the use of Mental Health Advance Directives, a method by which an individual can communicate their decisions about mental health treatment in advance of times when they are incapacitated.

4. Describe the person-centered planning process in your state
Individuals receiving their mental health treatment under the authorization of the managed care benefits participate in a collaborative treatment planning process. This process draws upon the needs identified across life domains during the assessment, as well as their strengths and challenges. Treatment is individualized and determined in partnership with the individual as well as those natural supports that the individual chooses to include in their care planning. Treatment plans often include client quotations that document their goals. These treatment plans are living documents that are revisited over the course of treatment and adapted based up on client needs and preferences. Programs such as WISe, Navigate, and PACT stress an even greater emphasis on person centered planning, as described above.

5. What methods does the SMHA use to encourage people who use the public mental health system to develop Psychiatric Advance Directives?
Chapter 71.32 of the revised code of WA requires behavioral health providers to ensure anyone accessing care and/or their caretakers be informed of advanced directives and supported in completing them if requested. At https://www.hca.wa.gov/free-or-low-cost-health-care/i-need-behavioral-health-support/mental-health-advance-directives HCA provides policy education and support to behavioral health providers toward this goal.

Program Integrity

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

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for M/SUD services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x–5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x-55(g), SAMHSA periodically conducts site visits to MHBG

and SUPTRS BG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SUPTRS BG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found on the SAMHSA website. at: ~~http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf~~. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SUPTRS BG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SUPTRS BG funds are allocated to support evidence-based, culturally competent programs, substance use primary prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

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

Please respond to the following:

1) Does the state have a specific policy and/or procedure for assuring that the federal program
requirements are conveyed to intermediaries and providers?
Yes

2) Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards?
Yes

3) Does the state have any activities related to this section that you would like to highlight?
DBHR program managers work with their contractors to review claims, identify overpayments, and educate providers and others on block grant program integrity issues.

DBHR also provides support and assistance to the Behavioral Health Administrative Service Organizations (BH-ASOs) and Tribes in their efforts to combat fraud and abuse as well as to promote best practices in an effort to raise awareness of fraud, waste, and abuse.

Contract requirements are passed down to subcontractors, which are reviewed and discussed prior to the subcontracts being sent out to providers. Contract managers conduct reviews at least once per year or once per biennium. Additional reviews may be done if there are challenges with providers or providers request technical assistance. In addition to contract monitoring, the Behavioral Health Administration, Division of Budget and Finance conducts an annual review of the BHOs' financial information. Part of the fiscal monitoring is to ensure that block grant funds are being used appropriately. If deficiencies are found, a corrective action plan is initiated and reviews occur more frequently.

On a monthly basis:

- Budget and Finance Division in conjunction with DBHR leadership conducts monthly reviews of the block grant budgets.
- Claim and payment adjustments are done as needed to ensure block grant expenditures are being properly recorded for allowable block grant services.
- Expenditure reports are reviewed monthly, and invoices are reviewed and approved by the contract manager prior to the payment being issued.
- Client level encounter, utilization, and performance analysis are completed as part of the invoice approval process and contract/fiscal monitoring process.

Tribes

*The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the **2009 Memorandum on Tribal Consultation**[56] to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.*

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

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should

be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that approximately 70 percent of American Indians and Alaska Natives do not live on tribal lands. The SMHAs, SSAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the states.

States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

- [56] ***https://www.energy.gov/sites/prod/files/Presidential%20Memorandum%20Tribal%20Consultation%20%282009%29.pdf***

Please respond to the following items:

1. **How many consultation sessions have the state conducted with federally recognized tribes?**

The State of Washington follows the Revised Code of Washington RCW 43.376 pertaining to the State's government-to-government relationship with Indian Tribes. All State agencies shall make reasonable efforts to collaborate with Indian tribes in the development of polices, agreements, and program implementation that directly affect Indian Tribe and develop a formal consultation policy. ~~https://app.leg.wa.gov/RCW/default.aspx?cite=43.376.020.~~ The WA State Health Care Authority is one of many state agencies that conducts several consultations each year following their HCA Consultation Policy. ~~https://www.hca.wa.gov/assets/program/tribal_consultation_policy.pdf.~~ Below is a listing of the consultations that have been conducted by the HCA over the past two years.

- Health Homes Roundtable/Consultations, Jan/Feb 2022
- Managed Care Organization Practices Consultation, Apr 2022
- Primary Case Management Entity (PCCMe), May 2022
- Medicaid Transformation Program Renewal/Native Hub, Jun 2022
- 988 Technical and Operation Plan, Sept 2022
- Opioid Abatement Settlement, Oct 2022
- 988 Comprehensive Assessment, Dec 2022
- Community Health Woker Grant Listening Session, Feb 2023
- Community Health Aide Program State Plan Amendment (SPA), Mar 2023
- 13d Rehabilitative Services SPA, Apr 2023
- Block Grant Listening Session, May 2023
- Opioid Settlement Listening Session, June 2023

- Block Grant Tribal Roundtable, July 2023
- Block Grant Tribal Roundtable 2, July 2023
- Block Grant Tribal Consultation, August 2023

The Health Care Authority follows a communication and consultation policy that government to government relationships and protocols for Tribes, Urban Indian health programs, and boarder tribes of Washington State.

2. What specific concerns were raised during the consultation session(s) noted above?

During the several consultations over the past couple of years, several main concerns have been raised by Tribal leaders and Tribal representatives regarding behavioral health services. Below is a summary of those concerns.

- This continues to be a significant concern for Tribes in which – Tribes have identified several gaps in access to services specifically for individuals that are not in managed care. Tribal representatives have identified access to care in accessing high acute evaluation and treatment services, detox services, secure withdrawal management, and crisis services. Some of these access to care concerns is said to be related to the low rates for individuals that are not in managed care when over 60% of the AI/AN population is not assigned to a managed care entity. This percentage is due to the risk of unintended negative impacts for AI/AN in receiving culturally appropriate care through Tribal services when opted into managed care. During legislative session the HCA submitted a request for funding to bring FFS up to parity with managed care rates which was supported by the Governor and passed through the legislature.
- Since 2020 the Tribes and Urban Indian Health Programs, raised significant concerns related to managed care practices in working with IHCPs and the challenges in receiving payments for Medicaid services ~~services~~ from Managed Care Organizations (MCO)s.
- When discussions of funding and contracting are discussed, Tribes continue to voice concerns regarding the administrative burden of managing federal pass-through dollars.
- Tribes have raised concerns about any requirements and language that only considers evidence-based practices as treatment modalities and does not consider that EBPs may not have enough evidence with under-represented communities and the lack of data for culturally based programs in being defined as an EBP. This language can at times place an unintended consequence to not consider culturally appropriate care and can also place stigma on culture-based modalities such as traditional healing practices.
- Tribes have also raised any issues of not having direct Tribal set asides for programs that are implemented by the State by being passed down to providers.

Tribal communities were impacted greatly by the COVID pandemic. Tribes were very proactive in addressing the pandemic for the health and safety of their people, closing non-emergency operations and limiting access to Tribal lands by early March 2020 prior to the Governor's Stay

at Home order. Due to this change, Tribes led efforts to identify innovative mechanisms to connect with their clients in treatment and within social services environments; however, restrictions and limitations on community events or gatherings were very difficult for tribal communities. Ceremony and traditional community gatherings are part of culture that has healed and supported tribal communities throughout the years. For example, the annual historical Canoe Journey, has been canceled for the past two years. Tribal communities have made difficult decisions to require changes for conducting traditional funeral ceremonies. In many communities, recovery support services were no longer held in person or were not scheduled due the need to social distance to keep people safe. As the pandemic continued, Tribal communities focused heavily on planning and preparing for the worst. When vaccinations became available, Tribes prioritized vaccine administration and education for elders, adults, employees, and community members, extending into vaccination of their surrounding communities.

One key issue that has been raised during this time is the significant increase in overdose rates amongst AI/AN individuals in WA State. In an early statistic, the overdose rates for AI/AN population had increased to over 150% during the first 6 months of the pandemic. The American Indian/Alaska Native Opioid Response workgroup provided a startling presentation of youth and adult opioid use and overdose rates over the course of the pandemic.

In response, Tribal communities, in partnership with Tribal lead organizations and federal and state partners, continue to work to address the behavioral health concerns of their Tribal members and community members while continuing to address this pandemic and to find innovative ways to reach their people for behavioral health needs. This includes having drive-thru wellness events, holding smaller gatherings, holding socially or physically distanced cultural activities, finding support for youth involved in online learning, improving telehealth resources, and improved internet access for their community members.

3. Does the state have any activities related to this section that you would like to highlight?

The Health Care Authority has several activities to improve access to behavioral health services for AI/AN individual and to engage in government-to-government partnership with Tribes.

- HCA Office of Tribal Affairs in partnership with the State legislature and the American Indian Health Commission, Northwest Portland Area Indian Health Board, and DOH, established the Tribal 988 Subcommittee focused on implementation of 988 and other crisis activities outlined in legislative bills, 1477 and 1134.
- HCA has worked to support the implementation of the Native and Strong Lifeline, Tribal 988 crisis line for Native individuals in WA. This includes support for direction of implementation alongside Tribal 988 Subcommittee and the Department of Health. HCA provided funding to launch a media campaign for both the Indian BH Hub and the NSL. HCA is supporting expansion of the Indian BH Hub for regional hub navigators.
- HCA continues to support managed care rapid response and D

- The HCA has worked extensively to ensure that MCOs pay Tribes at the encounter rate in a timely fashion. The HCA has implemented weekly rapid response calls, addressed issues directly with each MCO, extensively review of successful MCO payments to Tribes, and provided extensive TA and guidance to both IHCPs and MCOs.
- The HCA has several set-aside projects now being implemented through the HCA/Indian Nation Agreements with 28 of the 29 Tribes in Washington and also working to provide funding to urban Indian Health Organizations and other Tribal organizations.
- The HCA continues to support the work of the Tribal Centric Behavioral Health Advisory Board that focuses on crisis system improvements for AI/AN individuals and Tribal communities.
- The HCA continues to support the AI/AN Opioid Response Workgroup to address the Opioid Crisis and increase in opioid overdoses amongst AI/AN individuals following the pandemic and stay at home orders. And is now in year 5 of the implementation of the Tribal Opioid Solutions Campaign. This year, HCA partnered with the Department of Health with the same contractor working on the Opioid Solutions Campaign to develop the Tribal Suicide Prevention Campaign. These new campaign assets were launches at the same time and can be found of the following websites. The media firm working on these campaigns will also be providing technical assistance to Tribe and urban Indian organizations to localize these materials as well as launching a statewide media buy. https://watribalopioidsolutions.com/ , https://watribalopioidsolutions.com/suicide-prevention-toolkit
- The HCA has provided dedicated funds to offer free training to non-Tribal agencies and providers in working with AI/AN and navigation of the Indian Behavioral Health System. This included training to providers who support forensic behavioral health services, designated crisis responders, and HCA staff that oversee statewide behavioral health programs.
- The HCA successfully developed a State Plan Amendment to increase the rates for Tribal Residential SUD providers to $913 dollars as a cost-based rate. This SPA was approved by CMS paving the way for other upcoming Tribal Residential SUD providers to develop a cost-based rate that considerers the implementation of culturally and wrap around recovery support services in their residential SUD treatment programs.

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

None at this time.

Primary Prevention

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment. While primary prevention set-

aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. ***Information Dissemination*** *providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;*
2. ***Education*** *aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;*
3. ***Alternative programs*** *that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;*
4. ***Problem Identification and Referral*** *that aims at identification of those who have indulged in illegal/age-inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;*
5. ***Community-based Processes*** *that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and*
6. ***Environmental Strategies*** *that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.*

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Please respond to the following questions:

Assessment

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

2. **Does your state collect the following types of data as part of its primary prevention assessment process?**
   Yes. This assessment includes data on:
   a. Data on consequences of substance-using behaviors;
   b. substance-using behaviors;
   c. Intervening variables including (risk and protective factors); and
   d. Other: Local contributing factors.

3. **Does your state collect needs assessment data that include analysis of primary prevention needs for the following population groups?**
    a. Washington collects needs assessment data on the following population groups:
        i. Children (under age 12);
        ii. Youth (ages 12-17);
        iii. Young adults/college age (age 18-26);
        iv. Adults (ages 27-54);
        v. Cultural/ethnic minorities;
        vi. Sexual/gender minorities;
        vii. Rural communities; and
        viii. Other: Gender and sexual orientation of youth, Disability status of youth, Housing insecurity status of youth

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

    For its primary prevention needs assessment, Washington uses the following sources:
    - the National Survey on Drug Use and Health,
    - Behavioral Risk Factor Surveillance System,
    - Youth Risk Behavior Surveillance System,
    - Pregnancy Risk Assessment Monitoring System, and
    - Monitoring the Future.

    Washington additionally uses two state-developed survey instruments: the Healthy Youth Survey and the Young Adult Health Survey.

    The following indicators are used:
    a. WA Department of Health, Center for Health Statistics, Death Certificate Data :
        i.
        ii.
        iii. Alcohol related deaths;
        iv. Other drug related deaths;
        v. Opioid overdose deaths
        vi. Suicide Death Rates
    b. Uniform Crime Reporting:
        i. Alcohol related arrests
        ii. Drug related arrests
    c. Office of Superintendent of Public Instruction:
        i. High School On-Time / Extended Graduation Rates
    d. Comprehensive Hospital Abstract Reporting System (CHARS):
        i. Alcohol-Injury Related Hospitalizations
        ii. Any Non-Fatal Drug Overdose Hospitalizations
        iii. Any Non-Fatal Opioid Overdose Hospitalizations
        iv. Intentional Self-Harm Hospitalizations
    e. WA Department of Transportation and WA State Highway Safety Commission

i. Fatalities and Serious Injury from Crashes: Alcohol-Related Traffic Injuries and Alcohol-Related Traffic Fatalities.
ii. Young Drivers in Fatal Crashes Positive for Delta-9 THC

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

g. Washington Young Adult Health Survey:
i. Young Adult (18-25) Marijuana Misuse/Abuse;
ii. Opioid Misuse/Abuse;
iii. Alcohol Use; and
iv. Source of Marijuana.

h. Pregnancy Risk Assessment Monitoring System (PRAMS):
i. Pregnant Women Report Alcohol Use Any Time During Pregnancy
ii. Washington State Liquor and Cannabis Control Board:
i. Count of State Liquor Licenses;
ii. Count of State Marijuana Store Licenses and Processor Licenses

5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SUPTRS BG primary prevention funds?

Yes

a) If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based?

Programs, policies, and practices are determined to be evidence-based if they have been tested and shown favorable effects, plus no harmful effects, in one or more evaluation studies including at least one rigorous randomized controlled trial or two rigorous quasi-experimental evaluation studies. This is determined through a review of evidence-based

program registry ratings and/or a review of program evaluation literature by DBHR Prevention/Promotion staff with the assistance of university partners which is brought to the Evidence-Based Workgroup for consideration.

b) If no, (please explain) how SUPTRS BG funds are allocated:

6. Does your state integrate the National CLAS standards into the assessment step?
Yes

a) If yes, please explain below:
The DBHR Prevention Section utilizes CLAS standards into our assessment phase for Community Prevention Wellness Initiative (CPWI) community providers, including but not limited to:

- Coalition Progress Questionnaire which ensures coalitions are assessing how to improve access, retention, and relevance of prevention services to priority populations being served/not being reached by the grant.
- Coalition Assessment Tool which assesses the Coalition's ability to reach and serve populations of focus and includes a section that assesses the Coalition's perspective of how cultural competence/health equity are achieved through program delivery.
- The Healthy Youth Survey, which is used as the basis for the needs assessment of each coalition's strategic plan, assesses the SUD and behavioral health needs of students in each school being served by the grant. The HYS breaks down demographics (race, ethnicity, gender, sexual orientation status, etc.) per the CLAS standards principles, to ensure Coalitions are addressing health disparities in their planning and implementation.

b) If no, please explain in the box below.

7. Does your state integrate sustainability into the assessment step?
Yes
a) If yes, please explain in the box below.
Sustainability is integrated into the assessment step in a variety of ways, including:

- While Coalitions are completing their Resources Assessment, they consider what programs, policies, strategies, and initiatives exist within the local community to begin with, identifying where there may need to be support from the coalition or school to enhance or maintain prevention services.
- Building partnerships between the Coalitions and the school service areas so that building-level Healthy Youth Survey results can be easily shared and discussed in a collaborative way to support the coalition with strategic planning.
- Coalitions and Educational Services Districts building buy-in from stakeholders and partners in the schools in their service area to ensure continuing participation in the Healthy Youth Survey, as well as getting other eligible schools in those districts/regions to participate in the Healthy Youth Survey. This ensures ongoing eligibility for the BG funding and ability to expand the BG into new service areas if

they participate in the Healthy Youth Survey, as it is the mechanism for assessment and evaluation of SUD prevention services.

b) If no, please explain in the box below.

Capacity Planning

1. **Does your state have a statewide licensing or certification program for the substance misuse prevention workforce?**
   Yes. Through the Prevention Specialist Certification Board of Washington, the state provides a Certified Prevention Professional (CPP) credential. DBHR supports individuals in obtaining their CPP providing sessions of the Washington Substance Abuse Prevention Skills Training (SAPST) via contract with the Prevention Certification Board. Starting in 2015, DBHR contractually required credentialing of community coalition coordinators.
2. **Does your state have a formal mechanism to provide training and technical assistance to the substance misuse prevention workforce?**
   Yes. DBHR provides training and technical assistance for communities and prevention providers as they implement prevention services. The training plan covers the entire calendar year and includes the following components which provide a number of recurring workforce and capacity development opportunities in a variety of formats:

   - Coordinator trainings to increase prevention providers' capacity to implement the Washington Strategic Prevention Framework (SPF) model. These trainings include:
     - New Coordinator Basic Training – overview of Community Prevention and Wellness Initiative and SPF Models.
     - Community Data Book Training – how to use data to conduct a community needs assessment.
     - Goals, Objectives, Strategy Selection Training – how to prioritize local conditions and intervening variables to select program objectives and outcomes.
     - Evaluation Training – how to conduct an evaluation of programs and use results
     - CADCA Boot Camp – a four-day, interactive training to increase providers' capacity for coalition development.
   - Annual Training: DBHR hosts two state-wide conferences for prevention professional and community partner capacity building and youth prevention team capacity building.
     - These conferences provide educational and culturally competent training and networking opportunities for individuals and groups active in the field of prevention, including youth, volunteers, and prevention professionals. DBHR prevention staff participate both as presenters and attendees.
   - Monthly Training: DBHR hosts on-going, optional monthly training sessions during the 3rd hour of the on-line monthly CPWI Learning Community Meetings attended by sub-recipients.
     - Webinar training topics *include emerging research and data as well as information on evidence-based practices and strategies to support program implementation.*

- DBHR Technical Assistance Training and On-going Support:
    - DBHR provides regular and timely Technical Assistance to CPWI communities covering:
        - Budgeting;
        - Strategic plan development;
        - Action plan updates;
        - SPF implementation;
        - Contract compliance; and
        - The Substance User Disorder Prevention and Mental Health Promotion Online Management Information System (MIS);
    - In addition to live technical assistance, DBHR provides access to all training materials, shared documents, a calendar of events, and other resources on our workforce development and capacity development website, www.theAthenaForum.org.

3. **Does your state have a formal mechanism to assess community readiness to implement prevention strategies?**
   Yes. Washington has a formal mechanism to assess community readiness in collaboration with WA counties, Educational Service Districts (ESDs), and communities. DBHR joins with key partners and stakeholders to work with the highest need communities to follow a selection process that would identify if the communities were at a high enough level of readiness. This readiness was assessed by community support for developing and implementing the CPWI. This was determined by documenting support from at least eight (8) of the twelve (12) required community representative sectors that serve or live in the defined community and agree to join the coalition. Additionally, School District support was assessed and documented to leverage funding to support the required match costs for the Prevention/ Intervention specialist in the middle and or high school in the community. If a community was determined to not have enough readiness, the next highest need community was assessed for readiness. DBHR uses a request for application (RFA) process through which high-risk communities apply for funding which includes assessing community readiness DBHR monitors readiness in an ongoing way using a community progress tool and a community assessment tool.

Planning

1. **Does your state have a strategic plan that addresses substance misuse prevention that was developed within the last five years?**
   Yes. The first State of Washington Substance Abuse and Mental Health Promotion Five-Year Strategic Plan was developed in 2012. It was updated in 2015,2017, and 2019. A new 2023-2027 Strategic Plan is in process, set to be printed in July 2023. Past plans are posted at www.TheAthenaForum.org/spe. This strategic plan guides and coordinates the substance use disorder prevention and mental health promotion efforts across WA state agencies.
2. **Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SABG?**

Yes. Data prepared by the state SEOW supports the state's decision-making process regarding the use of the primary prevention set-aside of the SABG. The strategic plan is a guide for funding local prevention services and for dedicating state resources for local, regional, and state efforts. The most recent needs assessment was completed in 2022, which will be incorporated in the soon-to-be printed 2023-2027 Strategic Plan.

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

a. The state's prevention strategic plan includes the following components:
   i. Based on needs assessment datasets, the priorities that guide the allocation of SABG prevention funds;
   ii. Timelines;
   iii. Roles and responsibilities;
   iv. Process indicators;
   v. Outcome indicators;
   vi. Health equity in prevention;
   vii. Sustainability component.
   viii. Other:
      1. Resource assessment.
      2. Prevention research theories.
      3. Workforce development goals.
      4. Prevention/SUD policy tracking/review.

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

Yes we use two advisory groups:

1) The Washington State Prevention Enhancement Policy Consortium (the SPE Policy Consortium) provides this function. The SPE Policy Consortium is comprised of representatives from over 20 state and tribal agencies and organizations. The goal of the SPE Policy Consortium is that through partnerships Washington will strengthen and support an integrated system of community-driven substance abuse prevention programming, mental health promotion programming, and programming for related issues.
2) We have a Prevention and Promotion Advisory workgroup comprised on a diverse group of individuals that represent the various service delivery models we use to contract for services. This includes the CPWI coalition coordinators and prevention specialists, regional school staff from the Educational Service Districts, and community-based organizations and nonprofit organizations. This group meeting bi-monthly to dialogue with DBHR Prevention and Promotion section Manager to develop strategic solutions to challenges faced by the service providers such as contracting, workforce, and technical assistance needs. We also discuss developing enhancements to our service delivery system to better serve children and families. This last year we were fortunate to have the CSAP Deputy Director join us for one of our meetings. The group felt very honored.

5. **Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SABG primary prevention funds? If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based?**
   Yes. Washington State's Evidence-Based Program Workgroup (EBP Workgroup) determines a list of evidence-based programs and strategies that our sub-recipients for primary prevention services are permitted to select from. The list is posted on the Athena Forum website (https://www.TheAthenaForum.org/EBP). The EBP Workgroup is comprised of researchers and experts within and outside of Washington state, from University of Washington's Social Development Research Group and Washington State University's Improving Prevention through Action Research Lab, with input from the Washington State Institute for Public Policy, the prevention research sub-committee, and Pacific Institute for Research and Evaluation. The programs and strategies on the list originally come from three primary resources: the National Registry for Evidence-based Programs and Practices (NREPP), a separate list of programs identified as evidence-based by the State of Oregon; and the Pacific Institute for Research and Evaluation's (PIRE) "Scientific Evidence for Developing a Logic Model on Underage Drinking: A Reference Guide for Community Environmental Prevention" report. The list continues to be updated through a review of evidence informed by several evidence-based registries and reports, including Blueprints for Healthy Youth Development, California Evidence Based Clearinghouse, CrimeSolutions, and the Washington State Institute for Public Policy's various inventories of evidence-based and research-based child welfare and juvenile justice prevention programs.

Implementation

1. **States distribute SABG primary prevention funds in a variety of different ways.**
   a. The following apply in WA:
      i. SSA staff directly implements primary prevention programs and strategies;
      ii. The SSA has statewide contracts;
      iii. The SSA funds regional entities to provide prevention services;
      iv. The SSA funds county, city, or tribal government to provide prevention services; and
      v. The SSA funds community coalitions to provide prevention services.
      vi. The SSA funds individual programs that are not part of a larger community effort.
      vii. The SSA directly funds other state agency prevention programs.

2. **Please list the specific primary prevention programs, practices, and strategies that are funded with SABG primary prevention dollars in each of the six prevention strategies.**
   Along with the information presented here, the list of evidence-based programs and practices (direct and environmental) are posted in a searchable database found on the Athena Forum website (www.TheAthenaForum.org/ebp).
   Community-based Process – SABG supports the daily and ongoing coordination work of the Community Coalition Coordinator that staffs and supports the local (required) community coalition delivering substance use prevention services through the Community Prevention

and Wellness Initiative (CPWI). Funding for this category also supports Tribal staff to implement prevention programs via Indian Nation Agreements.

Information dissemination – SABG funding will continue to support efforts to raise awareness of risks associated with substance use and promote protective factors within communities. Prevention providers also promote local efforts and strategies.

Problem Identification and Referral – SABG funding will continue to support prevention/intervention staff (i.e., Student Assistance Professionals) in CPWI community schools. The Student Assistance Prevention-Intervention Services Program (SAPISP) is a comprehensive, integrated model of services that fosters safe school environments, promotes healthy childhood development and prevents alcohol, tobacco, and other drug abuse. Services include:

- Screening for high-risk behaviors.
- Consultation for parents and staff.
- Referrals to community services.
- Case management with school team.
- School-wide prevention activities.
- Professional consultation services.
- Informational workshops for parents, school staff, and community members.

Education – SABG funding will continue to support prevention services that provide education and communication from educators/facilitators to program participants (e.g., caregivers, youth, parents etc.) according to annual plans. This includes evidence-based parenting workshops, direct-service prevention programs for youth, and seminars/workshops.

Alternatives – SABG funding will continue to support substance-free activities, especially for youth. These activities provide safe and adult-monitored spaces for youth and teens, often in communities that do not have many other options for teens. These activities often also provide consistent and supportive relationships with other adults in the community (e.g., community center staff, etc.). Alternative activities are often used to complement or in conjunction with educational programs and strategies.

Environmental – SABG funds will continue to support the implementation of strategies that impact community-level change. Strategies focus on community norms, policies, and aspects of the built environment that impact availability, access, and enforcement to prevent youth substance use.

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

CSAP Category	Program Name
Alternatives	Tribal Traditional Teaching
Alternatives	Big Brothers Big Sisters Mentoring Program

Alternatives	Community Coalition
Alternatives	Gathering of Native Americans
Alternatives	Career Beginnings Mentoring Program
Community-Based Process	Community Coalition
Community-Based Process	Gathering of Native Americans
Community-Based Process	Youth Prevention Group
Community-Based Process	Communities That Care
Education	Strengthening Families Program: for Parents and Youth 10-14 (Iowa)
Education	Lions Quest Skills for Adolescence
Education	Life Skills Training Program (LST)
Education	Curriculum Based Support Group Program (CBSG)
Education	Incredible Years
Education	Class Action
Education	Project ALERT
Education	Hip-Hop 2 Prevent Substance Abuse and HIV (H2P)
Education	SPORT
Education	Positive Action
Education	Other-Innovative
Education	Reconnecting Youth
Education	Community Coalition
Education	Guiding Good Choices
Education	Parenting Wisely
Education	Too Good for Drugs
Education	Second Step
Education	Project Northland
Education	Alcohol Literacy Challenge (ALC)
Education	Nurse Family Partnership
Education	Al's Pals: Kids Making Healthy Choices
Education	Character Strong
Education	Love and Logic
Education	Keep a Clear Mind
Education	Children in Between
Education	I Can Problem Solve
Education	Strengthening Families Program (Utah)
Environmental	Policy Review and Development
Environmental	Social Host Ordinance
Environmental	Compliance Checks
Environmental	School Policies
Environmental	Advertising Restrictions
Environmental	Tobacco-Free Environmental Policies

Information Dissemination	Good Behavior Game
Information Dissemination	Public Awareness Campaign
Information Dissemination	Social Norms Marketing
Problem Identification and Referral	Project Success

Additionally, DBHR uses SABG funds for programs that have been identified as Other-Innovative in two of the six CSAP categories such as those below:

CSAP Category	Program Name
Alternatives	Other-Innovative
Environmental	Other-Innovative
Education	Other-Innovative

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

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

Evaluation

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

Yes. DBHR contracts with Washington State University to evaluate the effectiveness of the Community Prevention and Wellness Initiative (CPWI). CPWI is a strategic, data-informed, community coalition model aimed at preventing youth alcohol, tobacco, marijuana, opioid, and other drug use by targeting prevention efforts in the highest risk communities throughout the state (there are currently 96 CPWI communities).

This evaluation approach addresses two specific questions:

1) How do 10th Grade substance use and risk factors in CPWI communities change over time? and
2) Are the changes/trends over time different for CPWI communities compared to similar non-CPWI communities in Washington State? The evaluation draws from the state Healthy Youth Survey as well as community-level program and evaluation data. In addition, this effort evaluates community readiness (to implement CPWI) and characteristics of successful coalitions. Results of these evaluations are disseminated to CPWI communities and other stakeholders through reports, community presentations, and consultations. The evaluations products include the following:

- Developmental Trend Analysis Report (State Level)
- Impact Over Time Outcome Report (State Level)
- Community Readiness Report (State Level)
- Characteristics of Successful Coalitions Report (State Level)
- Community-Level Evaluation Summary Reports (Community Level)
- Community-Level Roll-Up Evaluation Report (State Level)
- Additional reporting through regional and national conferences and publications

2. Does your state's prevention evaluation plan include the following components?

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

b. Reports to sub-recipients

c. Evaluation of trainings offered by DBHR.

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

a. Washington collects the following measures:
   i. Numbers served (for individual participants, aggregate counts, and population reach);
   ii. Implementation fidelity;
   iii. Number of evidence based programs/practices/policies implemented;
   iv. Attendance;
   v. Target population
   vi. Target age group
   vii. Demographic information (age, race, ethnicity, income, language spoken, language ability, location, family military status; and
   viii. Other:
      1. Service hours.
      2. Number of Visitors to Table/Booth or Event.
      3. Number of Pick Ups/Destruction Trips.
      4. Number of Reverse Distributor Mailers Distributed.
      5. Number of Lock Boxes Distributed.

6. Number of Pounds Collected.
7. Number of materials distributed.
8. Number of People Reached by Radio Media Disseminated
9. Number of People Reached by TV
10. Number of People Reach By Newspaper/Press Release/Magazine Disseminated
11. Number of People Reach By Poster/Stickers Disseminated
12. Number of People Reach By Billboard Disseminated
13. Number of People Reached By Events
14. Number of Events
15. Number Users of Webpage
16. Number Unique Page Views of Webpage
17. Enter Number Followers on Social Media
18. Number of Social Media Posts (FB, Twitter, Etc) on Social Media
19. Number Clicked Post/Tweet (From All Posts/Tweets That Month) on Social Media
20. Number Who Reacted To Post To All Posts/Tweets (Liked/Shared/Commented) on Social Media
21. Social Media Display Ads
22. Enter Number of Website Clicks on Social Media Display Ads

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

a. WA Department of Health:
   i. Alcohol related injury/accident (hospitalization);
   ii. Other drugs related injury/accident (hospitalization);
   iii. Tobacco related deaths;
   iv. Alcohol related deaths;
   v. Other drug deaths – Drug related deaths; and
   vi. Opioid related deaths – All Opioids; Prescription; Heroin.

b. Uniform Crime Reporting:
   i. Arrests - Alcohol Violation;
   ii. Arrests – Alcohol Related;
   iii. Arrests – Drug Violation; and
   iv. Arrests – Drug Related.

c. Office of Superintendent of Public Instruction:
   i. High School Extended Graduation Rate (includes on-time graduation).

d. Comprehensive Hospital Abstract Reporting System (CHARS):
   i. Suicide and attempts.

e. WA Department of Transportation and WA State Highway Safety Commission
   i. Fatalities and Serious Injury from Crashes: Alcohol-Related Traffic Injuries and Alcohol-Related Traffic Fatalities.

f. Washington Healthy Youth Survey:
   i. Underage Drinking (10th Grade);

ii. Marijuana Use (10th Grade);
iii. Use of Prescription Drugs Not Prescribed (10th Grade);
iv. Pain Killer Use to get High (10th Grade)
v. Tobacco Use (10th Grade);
vi. E-Cigarette/Vapor Products Use (10th Grade);
vii. Polysubstance Use (10th Grade);
viii. Sad/Hopeless in Past 12 Months (10th Grade);
ix. Suicide Ideation (10th Grade);
x. Suicide Plan (10th Grade);
xi. Suicide Attempt (10th Grade);
xii. Bullied/Harassed/Intimidated (10th Grade);
xiii. Source of Alcohol, Pain Killers Used to Get High; Marijuana; Vapor Products (10th Grade);
xiv. Perception of Availability of Alcohol, Marijuana, Cigarettes; Opioids (10th Grade);
xv. Risk Perception of Alcohol, Marijuana (10th Grade); and
xvi. Knowledge of Laws, Perception of Enforcement – Alcohol, Marijuana (10th Grade)

g. Washington Young Adult Health Survey:
   i. Young Adult (18-25) Marijuana Use;
   ii. Alcohol Use; and
   iii. Source of Marijuana.

h. Pregnancy Risk Assessment Monitoring System (PRAMS):
   i. Pregnant Women Report Alcohol Use Any Time During Pregnancy.
   i. Washington State Liquor and Cannabis Control Board:
   i. Count of State Liquor Licenses;
   ii. Count of State Marijuana Store Licenses and Processor Licenses; and
   iii. Monthly revenue/sales of products.

Statutory Criterion for MHBG

Criterion 1: Comprehensive Community-Based Mental Health Service Systems
Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

1. **Describe available services and resources in order to enable individuals with mental illness, including those with co-occurring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.**

Contracts with Behavioral Health Administrative Service Organizations and Managed Care Organizations cover a wide variety of services in support of the individuals to live in their communities. Some examples of the services provided on a community level include crisis services, outpatient mental health counseling, group and family treatment, medication management, and medication monitoring. There is also higher level of outpatient resources such as intensive services for youth and families, respite services, the program of assertive community treatment (PACT), and high intensity services. Additional services to support individuals in the community include care coordination, engagement and outreach services, housing and recovery through peer services, mental health club houses, as well as supported employment.

2. **Does your state coordinate the following services under comprehensive community-based mental health service systems?**
    a. **Physical health** NO
    b. **Mental Health** YES
    c. **Rehabilitation services** YES
    d. **Employment services** YES
    e. **Housing services** YES
    f. **Educational services** YES
    g. **Substance misuse prevention and sub treatment services** YES
    h. **Medical and dental services** NO
    i. **Support services** YES
    j. **Services provided by local school systems under the individuals with disabilities education act (IDEA)** NO
    k. **Services for persons with co-occurring m/sud's** YES

Please describe or clarify the services coordinated, as needed (for example, best practices, service needs, concerns, etc.).

3. **Describe your state's case management services.**

While generic case management services are not included in Washington's Medicaid State Plan, as part of individual treatment services, mental health practitioners provide a range of activities in the community to further an individual's rehabilitative treatment goals. Activities would include skill modeling and training, assistance with ADLs. Additionally, Washington does have a service "Rehabilitative Case Management" which focuses on facilitating discharges from treatment institutions back into their community. This service includes warm handoffs to a community mental health provider and follow-up as needed to mitigate the risk or re-hospitalization. Activities include assessment for discharge or admission to community mental health care, integrated mental health treatment planning, resource identification and linkage to mental health rehabilitative services, and collaborative development of individualized services that promote continuity of mental health care. These specialized mental health coordination activities are intended to promote discharge, to maximize the benefits of the placement and to minimize the risk of unplanned readmission, and to increase the community tenure of the individual.

4. Describe actives intended to reduce hospitalizations and hospital stays.

Ensuring the right amount of care is available at the right time is key to reducing the need for hospitalization. Washington State requires each Behavioral Health Administrative Services Organization (BH ASO) and managed care entity within a designated region to ensure that a specific array of core mental health services are offered within the ASO and MCO's s network. These services span the continuum of care, ranging from less intensive outpatient services (i.e. therapeutic psychoeducation, brief intervention services, individual or group therapy), to more intensive multi-disciplinary team delivered services (i.e. Wraparound with Intensive Services, Program for Assertive Community Treatment), to more structured and stabilization focused care (i.e. mental health services in a residential setting, crisis stabilization services, evaluation and treatment in an inpatient setting). Peer support services are provided along the continuum of care, to promote a strength based and person-centered approach. Crisis outreach services and crisis support lines are offered on a 24/7 basis, always with the intention of offering the least restrictive alternative options to hospitalization. Washington State requires each BHO to meet and maintain network adequacy, appointment, response, and distance standards to ensure individuals have sufficient and timely access to care.

Appropriately decreasing the length of hospital stays and readmission rates hinges upon continuous and thorough discharge planning, as well as access to appropriate step-down options. Each BHO utilizes hospital liaisons within their region to assist with the discharge planning at the state hospitals, as well as the evaluation and treatment facilities. Washington State recently provided additional funding to the BH ASOs to further support dedicated discharge planners at the evaluation and treatment centers. Additionally, the state launched a Peer Bridger Pilot program that integrates peer counselors into each BH ASO hospital liaison team to facilitate discharge planning and to support successful transition and continuity of care as individuals return to their communities.

Appropriate step-down options are often hindered by a lack of safe and stable housing for individuals leaving a hospital setting. Washington has now entered into a five-year agreement with the Centers for Medicare and Medicaid Services (CMS) that provides federal funding for regional health system transformation projects. One of the three initiatives under this demonstration will focus on providing more supportive housing opportunities and services. It is anticipated that this increase in both funding and flexibility to help individuals with behavioral health needs obtain and maintain housing will bolster discharging efforts and enhance step down options.

Criterion 2 – Response to how the state calculates prevalence and incidence rates:
In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus.

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state's M/SUD system.

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

Target Population (A)	Statewide Prevalence (B)	Statewide Incidence (C)
Adults with SMI	103,208	N/A
Children with SED	40,319	N/A

Data Source: BHDS, P1 claims assumed to reflect MH services in the FIMC regions using a HCA approved algorithm with known limitations.
Washington State does not have a methodology or data to estimate incidence rates.

Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

Data Source: BHDS, P1 claims assumed to reflect MH services in the FIMC regions using an HCA approved algorithm with known limitations.
Washington State does not have a methodology or data to estimate incidence rates.

Criterion 3 – Provides for a system of integrated services for children to receive care for their multiple needs. Does your state integrate the following services into a comprehensive system of care?

1. Social services No
2. Education services, including services provided under IDE No
3. Juvenile justice services No
4. Substance misuse prevention and SUD treatment services No
5. Health and mental health services No
6. Establishes defined geographic area for the provision of services of such system. Yes

Criterion 4 – Response to question:

a. **Describe your state's targeted services to rural population.**

Washington State requires each Behavioral Health Administrative Services Organization (BH ASO) and managed care entities within a designated region to maintain an adequate provider network that meets the specific regional needs. For rural areas, the BH ASOs and MCOs must ensure that the location of their providers are within reasonable maximum distance standards. In addition, the state imposes access requirements through contract which requires the MCOs to provide community-based intake assessments at an individual's home or living facility, such as assisted living, adult family home, or skilled nursing facility.

b. Describe your state's targeted services to the homeless population
Washington State supports several programs throughout the state that provide targeted outreach to homeless individuals. Projects for Assistance in Transition from Homeless (PATH) provides persistent and consistent outreach to individuals experiencing homelessness to assist in accessing housing, behavioral health services, and other services to facilitate recovery and stabilization. Housing and Recovery through Peer Services (HARPS) is a team-based approach, utilizing certified peer counselors and mental health professionals to provide community-based services to at risk individuals. Priority populations for HARPS services include individuals who are homeless or at risk at becoming homeless, as well as individuals discharging from inpatient psychiatric settings.

c. Describe your state's targeted services to the older population.
Regarding serving the older adult population, the MCOs must provide or purchase age appropriate and culturally competent community behavioral health services for their enrollees whom services are medically necessary and clinically appropriate. Plans are required to analyze demographic data (including age) at least annually, to determine if their network is adequately serving the population of that region and to inform ongoing quality improvement. Providers within the networks are required to provide onsite intake assessments and services at assisted living facilities, skilled nursing facilities, and adult family homes when requested by either the individual or the facility. Washington State ensures that Preadmission Screening and Resident Review (PASRR) are conducted statewide to ensure that individuals with mental health needs referred to skilled nursing facilities are not inappropriately placed in nursing homes.

Criterion 5 – Describe your state's management systems.
DBHR uses MHBG funds to purchase and provide training to community mental health providers across the state. Examples of training include:

- Training in PACT fidelity and technical assistance and those EBPs included in the PACT model (CBT, Supported Employment, and Supportive Housing),
- Supportive Housing,
- Supported Employment,
- and Cognitive Behavioral Therapy for Psychosis.

DBHR also purchases training for increasing the workforce of Certified Peer Counselors and provides training for Designated Mental Health Professionals who are responsible for providing on-site emergency evaluations of individuals who may need voluntary or involuntary treatment. Since April 1, 2018, these individuals have also been responsible for responding to emergencies with either mental health issues or issues revolving around substance use disorders. We trained the entire statewide work force in conducting SUD evaluations and co-occurring evaluations for voluntary and involuntary treatment.

Footnotes (For criterion 5):

Wraparound with Intensive Services (WISe), a service delivery model, provides children and youth service coordination to receive care for their multiple needs. WISe is designated to provide comprehensive behavioral health services and supports to Medicaid eligible individuals, up to 21 years of age with complex behavioral health needs. Youth with complex needs are usually involved in more than one child serving system such as child welfare, juvenile justice, social services and education. WISe requires referral and coordination with various services and systems. WISe also requires a single Cross System Care Plan based on the child/youth individual needs and the other child serving systems involved in their lives.

Substance Use Disorder Treatment

Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs.

Improving access to treatment services

1. Does your state provide:
    a) A full continuum of services:
        i) Screening
        Yes

        ii) Education
        Yes

        iii) Brief intervention
        Yes

        iv) Assessment
        Yes

        v) Detox (inpatient/social)
        Yes

        vi) Outpatient
        Yes

        vii) Intensive outpatient
        Yes

        viii) Inpatient/residential
        Yes

        ix) Aftercare; recovery support
        Yes

b) Services for special populations:

Targeted services for veterans?
No

Adolescents?
Yes

Older adults?
No

Medication-Assisted Treatment (MAT)?
Yes

Criterion 3: Pregnant Women and Women with Dependent Children (PWWDC)

1. Does your state meet the performance requirement to establish and or maintain new programs or expand programs to ensure treatment availability?
   a) Yes
2. Does your state make prenatal care available to PWWDC receiving services, either directly or through an arrangement with public or private nonprofit entities?
   a) Yes
3. Have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care?
   a) **Yes**
4. Does your state have an arrangement for ensuring the provision of required supportive services?
   a) **Yes**
5. Has your state identified a need for any of the following:
   a) Open assessment and intake scheduling?
   Yes
   b) Establishment of an electronic system to identify available treatment slots?
   Yes
   c) Expanded community network for supportive services and healthcare?
   Yes
   d) Inclusion of recovery support services?
   Yes
   e) Health navigators to assist clients with community linkages?
   Yes
   f) Expanded capability for family services, relationship restoration, and custody issues?
   Yes
   g) Providing employment assistance?
   Yes
   h) Providing transportation to and from services?
   Yes

i) Educational assistance?
No

6**. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.**

Strategies for prioritizing pregnant individuals are contained within the contract language between the state of Washington and the Managed Care Organizations (MCOs). The MCOs must publicize the availability of treatment services to PPW clients at the facilities, as well as the fact that PPW clients receive priority admission.
The MCOs work with agencies to get pregnant individuals into services within 24 hours, and if a residential placement is not available interim services are provided. If residential treatment is not needed, the individual is enrolled in outpatient treatment. When services are not available, the provider is required to ensure the following:

- Provision of, referral to, or counseling on the effects of alcohol and drug use on the fetus.
- Referral to prenatal care.
- Provision of, or referral to, human immunodeficiency (HIV) and tuberculosis (TB) education.
- Referral for HIV or TB treatment services if necessary.
- PPW receiving treatment are treated as a family unit.

The following services are provided directly or arrangements are made for the provision of the following services with sufficient case management and transportation to ensure women and their children have access to services provided below:

- Primary medical care for women, including referral for prenatal care and childcare while the women are receiving such services.
- Primary pediatric care including immunization for their children.
- Gender specific SUD treatment and other therapeutic interventions for women which may address issues of relationships, sexual and physical abuse, and parenting are provided.
- Provide, directly or through arrangements with other public or nonprofit private entities, childcare to individuals participating in assessment and treatment activities, and supportive activities such as support groups, parenting education, and other supportive activities when those activities are recommended as part of the recovery process noted in the individual's treatment plan.
- Therapeutic interventions for children in custody of individuals who identify as women treatment which may, among other things, address their developmental needs, their issues of sexual abuse and neglect.
- Substance Used Disorder Assessment Services specific to PPW.
- Services specific to Post-Partum Women.
- Services may continue to be provided for up to one year postpartum.

The MCOs must ensure assessment requirements in addition to standard assessment service, to include a review of the gestational age of fetus, mother's age, living arrangements, and family support data.

A pregnant woman who is unable to access residential treatment due to lack of capacity and is in need of detoxification, can be referred to a Chemical Using Pregnant (CUP) program for admission, typically within 24 hours.

Criteria 4, 5 and 6: Persons Who Inject Drugs (PWID), Tuberculosis (TB), Human Immunodeficiency Virus (HIV), Hypodermic Needle Prohibition, and Syringe Services Program

Persons Who Inject Drugs (PWID)
1. Does your state fulfill the:

a) 90 percent capacity reporting requirement?
Yes
b) 14-120 day performance requirement with provision of interim services?
Yes
c) Outreach activities?
Yes
d) Syringe services programs?
Yes
e) Monitoring requirements as outlined in the authorizing statute and implementing regulation?
Yes

2. **Has your state identified a need for any of the following:**

a) Electronic system with alert when 90 percent capacity is reached?
No
b) Automatic reminder system associated with 14-120 day performance requirement?
No
c) Use of peer recovery supports to maintain contact and support?
Yes
d) Service expansion to specific populations (e.g., military families, veterans, adolescents, older adults)?
No

3. **States are required to monitor program compliance related to activities and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.**

Strategies for prioritizing persons who inject drugs (PWID) is contained within the contract language between the state of Washington and the MCOs. The MCOs must publicize the

availability of treatment services to PWID at the facilities, as well as the fact that PWID receive priority admission. In addition, the MCOs must ensure that outreach is provided to priority populations. The outreach activities must be specifically designed to reduce transmission of HIV and encourage PWID to undergo treatment.
If treatment services are not immediately available, then interim services are made available until an individual is admitted to a substance abuse treatment program. The purpose of the service is to reduce the adverse health effects of such abuse, promote the health of the individual, and reduce the risk of transmission of the disease.
The MCOs are required to submit a yearly project plan on how the services and the requirements in the contract will be adhered to. The project plans are reviewed and approved by DHBR. The MCOs are required to submit annual progress reports that include what outreach models were used to PWID to enter treatment.

Tuberculosis (TB)

1**. Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery?**

a) **Yes**

2. Has your state identified a need for any of the following:

a) Business agreement/MOU with primary healthcare providers?
Yes
b) Cooperative agreement/MOU with public health entity for testing and treatment?
Yes
c) Established co-located SUD professionals within FQHCs?
No

3. **States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.**

The MCOs must directly or through arrangement with other public entities, make tuberculosis services available to individuals receiving SUD treatment. The services must include tuberculosis counseling, testing, and provide for or referring individuals infected with tuberculosis for appropriate medical evaluation and treatment.
In the case an individual in need of treatment services is denied admission to the tuberculosis program based on the lack of capacity the MCO will refer the individual to another provider of tuberculosis services. The MCOs must conduct case management activities to ensure the individual receives tuberculosis services.

Early Intervention Services for HIV (For "Designated States" Only)

1**. Does your state current have an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIV in areas that have the greatest need for such services and monitoring such service delivery?**

No

2. **Has your state identified a need for any of the following:**

a) Establishment of EIS-HIV service hubs in rural areas?

No

b) Establishment or expansion of tele-health and social media support services?

Yes

c) Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS?

No

Syringe Service Programs

1. Does your state have in place an agreement to ensure that SABG funds are NOT expended to provide individuals with hypodermic needles or syringes (42 U.S.C.§ 300x-31(a)(1)F)?

Yes

2) Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program?

No

3) Do any of your programs use SABG funds to support elements of a Syringe Services Program?

a) No

b) If yes, please provide a brief description of the elements and the arrangement

Criteria 8, 9 and 10: Service System Needs, Service Coordination, Charitable Choice, Referrals, Patient Records, and Independent Peer Review

Service System Needs

1. **Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention, and treatment authorized services available, identified gaps in service, and outlines the state's approach for improvement?**

Yes

2. **Has your state identified a need for any of the following:**

a) Workforce development efforts to expand service access?

Yes

b) Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services?

Yes

c) Establish a peer recovery support network to assist in filling the gaps?

Yes

d) Incorporate input from special populations (military families, service members, veterans, tribal entities, older adults, sexual and gender minorities)

No

e) Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, such as primary healthcare, public health, VA, and community organizations

No

f) Explore expansion of services for:

i) MAT

(1) Yes

ii) Tele-health

(1) Yes

iii) Social media outreach

(1) Yes

Service Coordination

1. **Does your state have a current system of coordination and collaboration related to the provision of person-centered and person-directed care?**

Yes

2. **Has your state identified a need for any of the following:**

a) Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services

Yes

b) Establish a program to provide trauma-informed care

Yes

c) Identify current and perspective partners to be included in building a system of care, such as FQHCs, primary healthcare, recovery community organizations, juvenile justice system, adult criminal justice system, and education

Yes

Charitable Choice

1. **Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (42 U.S.C.§ 300x-65, 42 CF Part 54 (§54.8(b) and §54.8(c)(4)) and 68 FR 56430-56449)?**

Yes

2. Does your state provide any of the following:

a) Notice to Program Beneficiaries?

No

b) An organized referral system to identify alternative providers?

Yes

c) A system to maintain a list of referrals made by religious organizations?

No

Referrals

1. **Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs?**

Yes

2. Has your state identified a need for any of the following:

a) Review and update of screening and assessment instruments?

Yes

b) Review of current levels of care to determine changes or additions?

Yes

c) Identify workforce needs to expand service capabilities?

Yes

d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background?

Yes

Patient Records

1. **Does your state have an agreement to ensure the protection of client records?**

a) Yes

2. Has your state identified a need for any of the following:

a) Training staff and community partners on confidentiality requirements?

Yes

b) Training on responding to requests asking for acknowledgement of the presence of clients?

Yes

c) Updating written procedures which regulate and control access to records?

Yes

d) Review and update of the procedure by which clients are notified of the confidentiality of their records include the exceptions for disclosure?

Yes

Independent Peer Review

1**. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers?**

a) **Yes**

2. **Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C.§ 300x-52(a)) and 45 § CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program involved.**

a) Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved

The state completes an annual independent peer review of its providers. The BH-ASO regions are required to submit the names of providers who will be reviewed as well as independent peer reviewers from each of the regions in the state. The state has an administrative policy in place that defines the purpose and scope of the reviews. The plan for the FFY22 review will have 10 substance use treatment providers (10%) to be reviewed and 7 mental health providers (11%) to be reviewed. Reviews are happening during August and September 2023.

3. **Has your state identified a need for any of the following:**

a) Development of a quality improvement plan?

Yes

b) Establishment of policies and procedures related to independent peer review?

Yes

c) Development of long-term planning for service revision and expansion to meet the needs of specific populations

Yes

4. **Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, such as the Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds?**

a) **No**

b) **If Yes,** please identify the accreditation organization(s)

i) Commission on the Accreditation of Rehabilitation Facilities

ii) The Joint Commission

iii) Other (please specify)_____

Criterion 7 and 11: Group Homes for Persons In Recovery and Professional Development Group Homes

1. **Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program?**

Yes

2. Has your state identified a need for any of the following:

a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service?

Yes

b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing?

Yes

Professional Development

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opportunity to receive training on an ongoing basis, concerning:

a) Recent trends in substance use disorders in the state?

Yes

b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services?

Yes

c) Performance-based accountability?

Yes

d) Data collection and reporting requirements?

Yes

2. Has your state identified a need for any of the following:

a) A comprehensive review of the current training schedule and identification of additional training needs?

Yes

b) Addition of training sessions designed to increase employee understanding of recovery support services?

Yes

c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services?

Yes

d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort?

Yes

3. Has your state utilized the Regional Prevention, Treatment and/or Mental Health Training and Technical Assistance Centers (TTCs)?

a) Prevention TTC?
Yes

b) Mental Health TTC?
No

c) Addiction TTC?
Yes

d) State Targeted Response TTC?
No

Waivers

Upon the request of a state, the Secretary may waive the requirements of all or part of the sections 1922(c), 1923, 1924 and 1928 (42 U.S.C. § 300x-32(f)).

1. Is your state considering requesting a waiver of any requirements related to:

a) Allocations Regarding Women
No

2. **Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus**

a) Tuberculosis
No

b) Early Intervention Services Regarding HIV
No

3. **Additional Agreements**

a) Improvement of Process for Appropriate Referrals for Treatment
No

b) Professional Development
No

c) Coordination of Various Activities and Services
No

Please provide a link to the state administrative regulations that govern the Mental Health and Substance Use Disorder Programs.
https://apps.leg.wa.gov/wac/default.aspx?cite=182

Crisis Services

Substance Abuse and Mental Health Services Administration (SAMHSA) is directed by Congress to set aside 5 percent of the Mental Health Block Grant (MHBG) allocation for each state to support evidence-based crisis systems. The statutory language outlines the following for the 5 percent set-aside:

....to support evidenced-based programs that address the crisis care needs of individuals with serious mental illnesses and children with serious emotional disturbances, which may include individuals (including children and adolescents) experiencing mental health crises demonstrating serious mental illness or serious emotional disturbance, as applicable.

CORE ELEMENTS: At the discretion of the single State agency responsible for the administration of the program, the funds may be used to expend some or all of the core crisis care service components, as applicable and appropriate, including the following:

- *Crisis call centers*
- *24/7 mobile crisis services*
- *Crisis stabilization programs offering acute care or subacute care in a hospital or appropriately licensed facility, as determined by such State, with referrals to inpatient or outpatient care.*

  STATE FLEXIBILITY: In lieu of expanding 5 percent of the amount the State receives pursuant to this section for a fiscal year to support evidence based programs as required a State may elect to expend not less than 10 percent of such amount to support such programs by the end of two consecutive fiscal years.

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-intervention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination, stabilization service to support reducing distress, promoting skill development and outcomes, manage costs, and better invest resources.

*SAMHSA developed **Crisis Services: Meeting Needs, Saving Lives**, which includes "**National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit**" as well as an **Advisory: Peer Support Services in Crisis Care** and other related National Association of State Mental Health Programs Directors (NASMHPD) papers on crisis services. SAMHSA also developed "**National Guidelines for Child and Youth Behavioral Health Crisis Care**" which offers best practicies, implementation strategies, and practical guidance for the design and development of services that meet the needs of children, youth and their families experiencing a behavioral health crisis. Please note that this set aside funding is dedicated for the core set of crisis services as directed by Congress. Nothing precludes states from utilizing more than 5 percent of its MHBG funds for crisis services for individuals with serious mental illness or children with serious emotional disturbances. If states have other investments for crisis services, they are encouraged to coordinate those programs with programs supported by this new 5 percent set aside. This*

coordination will help ensure services for individuals are swiftly identified and are engaged in the core crisis care elements.

Briefly narrate your state's crisis system. For all regions/areas of your state, include a description of access to the crisis call centers, availability of mobile crisis and behavioral health first responder services, utilization of crisis receiving and stabilization centers.

Washington's crisis system is operated at the regional level based on a framework overseen by HCA. HCA contracts with 10 regional Behavioral Health Administrative Organizations (BH-ASO). The BH-ASOs in each region contract with behavioral health agencies to operate mobile crisis, regional crisis lines, and crisis stabilization units. Washington passed a line tax 988 in 2021 and set out a plan to implement 988 and elements of SAMHSA's best practices. With the passage of this legislation planning work has been ongoing to implement a technology solution to coordinate the crisis system. The legislation also created the Crisis Response Improvement Strategy (CRIS) committee that has 36 members from diverse viewpoints to guide implementation of the crisis system improvements.

988 is available statewide covered by 3 contact centers in the state. Each region has a regional crisis line that is separate from 988 at this time and is the primary contact center in a region for access to the crisis system. Work is underway to bring these regional lines in alignment with 988.

There is currently a youth and adult mobile crisis team in each region of the state. The state as a whole is working to expand mobile crisis to improve response times across the state. Recent investments have added 12 new teams and a further round of investment will allow the state to expand further. Washington is undergoing standardization and improvement of mobile crisis including the ability to transport and standard training through an endorsement process. Washington has a crisis stabilization unit in 8 out of 10 regions in the state with plans to add more facilities in the state. A recent round of capital funds has allocated funding for 6 more facilities in the state. Washington does have some crisis receiving centers in the state, but recently passed legislation will make implementing them easier and standardized. The new rules for facilities will improve access to crisis relief centers.

2. In accordance with the guidelines below, identify the stages where the existing/proposed system will fit in.

a) The Exploration stage: is the stage when states identify their communities' needs, assess organizational capacity, identify how crisis services meet community needs, and understand program requirements and adaptation.
b) The Installation stage: occurs once the state comes up with a plan and the state begins making the changes necessary to implement the crisis services based on the SAMHSA guidance. This includes coordination, training and community outreach and education activities.
c) Initial Implementation stage: occurs when the state has the three-core crisis services implemented and agencies begin to put into practice the SAMHSA guidelines.

d) Full Implementation stage: occurs once staffing is complete, services are provided, and funding streams are in place.
e) Program Sustainability stage: occurs when full implementation has been achieved, and quality assurance mechanisms are in place to assess the effectiveness and quality of the crisis services.

Other program implementation data that characterizes crisis services system development.

1. *Someone to talk to: Crisis Call Capacity*
   a. *Number of locally based crisis call Centers in state*
      i. *In the 988 Suicide and Crisis lifeline network*
      ii. *Not in the suicide lifeline network*
   b. *Number of Crisis Call Centers with follow up protocols in place*
   c. *Percent of 911 calls that are coded as BH related*
2. *Someone to respond: Number of communities that have mobile behavioral health crisis mobile capacity (in comparison to the total number of communities)*
   a. *Independent of first responder structures (police, paramedic, fire)*
   b. *Integrated with first responder structures (police, paramedic, fire)*
   c. *Number that employs peers*
3. *Safe place to go or to be:*
   a. *Number of Emergency Departments*
   b. *Number of Emergency Departments that operate a specialized behavioral health component*
   c. *Number of Crisis Receiving and Stabilization Centers (short term, 23-hour units that can diagnose and stabilize individuals in crisis)*

a. Check one box for each row indicating state's stage of implementation

	Exploration Planning	Installation	Early Implementation Less than 25% of counties	Partial Implementation About 50% of counties	Majority Implementation At least 75% of counties	Program Sustainment
Someone to talk to						X
Someone to respond					X	
Safe place to go or to be					X	

b. Briefly explain your stages of implementation selections here.
Washington has fully implemented and staffed its 988 contact centers. We would have chosen fully implemented because there is still work to improve infrastructure and coordination, but that was not an option. We are still implementing new standards and expanding someone to respond category with plans to add more teams in the next few years as funding and workforce allow. The "safe place to go or to be" is still under development. We are expanding facilities and implementing crisis relief centers with the passage of SB 5120 this year, but most are still under construction. For a "safe place to be" we are expanding the MRSS model in the state by implementing youth focused crisis response teams.

3. Based on SAMHSA's National Guidelines for Behavioral Health Crisis Care, explain how the state will develop the crisis system.
Washington State has passed comprehensive legislation in the past few years to implement SAMHSA's best practices in the state. Starting with HB 1477 passed in 2021 that implemented critical planning processes and infrastructure for future crisis contact hubs. Key components of this legislation include the creation of the Crisis Response Improvement Strategy committee that brings diverse views to make recommendations on how to implement changes to the crisis system. It also laid out criteria for a technology platform to be used by 988 hubs. It also created the first in the country requirements for fully funded commercial plans to make next day appointments available to their enrollees.

Washington has invested heavily in the crisis system. The state has worked to expand and standardize crisis response and facilities in the state adding 17 new teams in 2022 to ensure there is one team per region. New program standards have been implemented and data collection mechanisms are being implemented. The state has also worked to implement more crisis stabilization units working to add 10 more across the state. In the spring of 2023, the state passed HB 1134 which contains requirements for more standards for mobile crisis response and an emphasis on regional analysis of needs.

4. Briefly describe the proposed/planned activities utilizing the 5 percent set aside.
Washington will be substantially expanding mobile crisis outreach services including child/youth teams on a statewide basis. Recently passed legislation will improve availability of crisis relief centers, mobile crisis, and community-based crisis intervention services in the state with a goal of response times almost on par with other first responders. Block grant 5% set aside crisis funding will be used to augment the statewide crisis system, primarily distributed through our Behavioral Health Administrative Service Organizations (BH-ASOs) for use within their regions. Additionally, HCA will use some of the funding to provide state sponsored trainings for Designated Crisis Responders.

We will also provide funding to Washington Tribes for crisis treatment services and the tribal crisis coordination hub:

- Support for a tribal crisis coordination hub:
  - Help crisis providers place clients at appropriate inpatient treatment facilities or connect clients with appropriate intensive outpatient treatment;

    - Compile and submit crisis reports and data to the state's data store;
    - Provide training and support to crisis providers, with a focus on providing culturally appropriate services and effective coordination of care and discharge planning for American Indian and Alaska Native (AI/AN) clients receiving crisis treatment;
- Non-Medicaid crisis treatment services provided by tribal and other Indian health care providers; and
- Capacity building efforts to enable tribal and other Indian health care providers to offer effective and culturally appropriate crisis services to AI/AN clients, with support for care coordination and transition planning for clients who have experienced crisis.

Please indicate areas of technical assistance needed related to this section.
We have provided an introductory training to mobile crisis providers across the state on harm reduction. We request technical assistance with identifying any available harm reduction trainings and materials, with a focus on behavioral health crisis intervention, that can be utilized to deepen the knowledge and skill set of our crisis system providers.

Recovery

Recovery supports and services are essential for providing and maintaining comprehensive, quality M/SUD care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders.

Recovery is supported through the key components of: health (access to quality health and M/SUD treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery- guided the approach to person-centered care that is inclusive of shared decision-making, culturally welcoming and sensitive to social determinants of health. The continuum of care for these conditions involves psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder, and services to reduce risk related to them. Because mental and substance use disorders can become chronic relapsing conditions, long term systems and services are necessary to facilitate the initiation, stabilization, and management recovery and personal success over the lifespan.

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

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

In addition, SAMHSA identified 10 guiding principles of recovery:

- *Recovery emerges from hope;*
- *Recovery is person-driven;*

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

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

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the SAMHSA supported Technical Assistance and Training Centers in each region. SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

1. Does the state support recovery through any of the following:

a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care?

☒Yes No

b) Required peer accreditation or certification?

☒Yes No

c) Block grant funding of recovery support services?

☒Yes No

d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system?

☒Yes No

2. Does the state measure the impact of your consumer and recovery community outreach activity?

☒Yes No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

In 2015, Washington applied for a Centers for Medicaid/Medicare (CMS) 1115 Medicaid Transformation Project (MTP) waiver to provide supportive housing and supported employment services to individuals receiving Medicaid and who meet specific risk criteria. These services are collectively known as Foundational Community Supports. Individuals with SMI including youth 16 and up (with SED) are eligible for supported employment services. According to the Substance Abuse and Mental Health Services Administration's (SAMHSA) research, about 70 percent of adults with serious mental illnesses desire work. (Mueser et al., 2001; Roger et al., 2001). Supported Employment, also known as the Individual Placement and Support (IPS) model has been proven effective in at least 27 randomized, controlled trials. The 1115 MTP waiver provides supportive housing support services to assist individuals obtain and maintain housing using SAMHSA's evidence-based practice permanent supportive housing. Both Supportive Housing and Supported Employment Services are available to individuals with SMI and SUD conditions.

Since launching FCS in 2018, the program has enrolled nearly 20,000 unique individuals across Washington state. The program has launched numerous initiatives made possible through the use of Substance Abuse and Mental Health block grant funds to expand the reach of the program and the quality of these support services. To help ensure and improve upon the quality of FCS services, the state regularly incentivizes FCS providers to take part in the FCS fidelity reviews. These reviews embody a learning collaborative approach to improving the quality of supportive housing and supported employment services. SABG and MHBG funds have played a pivotal role in paying for agencies to send staff to participate on reviews, as well as host a baseline and follow-up review of their FCS services. These reviews present providers with the opportunity to learn and share best practices with other providers in the network.

To support FCS providers, the state has launched two rounds of grants to assist SUD treatment providers with the infrastructure necessary to join the FCS network and start supportive housing and/or supported employment services, which to date has brought in 17 new provider organizations with a focus on individuals with SUD. In early 2021, the state also began an interagency project that will see the creation of a virtual discharge planners toolkit aimed at connecting individuals exiting institutional settings to the various recovery support services available in Washington.

In late 2020, Washington received the authorization from CMS to expand FCS supportive housing services to Institution for Mental Disease (IMD) settings, in alignment with initiatives 4 and 5 of the MTP waiver. Historically, individuals with lengthy stays in IMD settings have been precluded from receiving FCS services due to Medicaid suspension and other challenges, which makes an individual ineligible from FCS. The state identified this as a gap in service coverage that might also prevent an FCS provider from working on a supportive housing plan with individuals in an IMD setting. However, as part of the COVID relief funds through SABG and

MHBG, FCS will be able to reimburse supportive housing services to providers working with individuals as they transition from these settings to the community who lose their Medicaid eligibility.

The state received a one-year extension of the 1115 MTP waiver for calendar year 2022, which allowed the ability to continue services and make up for time lost due to addressing the COVID 19 pandemic. During this time, the state formally applied for a five-year renewal of MTP, which includes Foundational Community Supports as one of the initiatives continuing under the waiver. As part of the application, the state requested short-term rental assistance including one-time transition costs and six months' rent coverage for enrollees experiencing homelessness, who are at risk of homelessness, or transitioning out of institutional settings. Due to the application being submitted in July 2022, the state received a temporary 6-month extension of the waiver from January through June 2023.

In May of 2022, Washington started offering short-term rental assistance for Foundational Community Supports participants through its Transition Assistance Program (TAP). TAP is funded by state-only dollars and can pay for the short-term financial barriers to obtaining stable housing, including deposits, one-time fees, and first and last month's rent. The program also covers basic home goods and light furnishings. From launch to May 2023, TAP has served approximately 2,000 individuals.

In addition to the Foundational Community Supports, the Housing and Recovery through Peer Services (HARPS) is available to individuals with serious mental illness and co-occurring at risk of exiting to homelessness or at risk of entering inpatient behavioral health settings. HARPS provides participants with meaningful choice and control of housing and support services, using certified peer counselors who are trained as housing specialists. The HARPS project reduces homelessness and supports the recovery and resiliency of individuals with serious mental illness, co-occurring mental health and substance use disorders. HARPS provides permanent supportive housing pre-tenancy and tenancy sustaining services to individuals. HARPS also includes a shallow bridge subsidy to assist with rent, deposits, application fees etc.

Peer Support services have been a Medicaid reimbursable service since 2005. Peer Support Services were added to the Substance Use Disorder State Plan in 2019 and we updated our eligibility criteria for people to become Certified Peer Counselors to include people whose lived experience was substance use only. Certified peer counselors provide recovery supports in a variety of behavioral health settings including but not limited to community behavioral health agencies, peer run agencies, homeless outreach programs, evaluation and treatment programs and hospitals. Peer services increase empowerment, champion hope, and promote the expectation that recovery is possible for everyone.

Washington's Peer Support program has trained and qualified mental health consumers as certified peer counselors since 2005. A "consumer" is someone who has applied for, is eligible for, or who has received mental health services. This also includes parents and legal guardians

when they have a child under the age of 13, or a child 13 or older and they are involved in their treatment plan.

Washington's Peer Bridger Program connects Certified Peer Counselors with people transitioning from inpatient settings to share a message of hope and recovery and help them 'bridge' from an inpatient setting to success in their community. Peer Bridgers provide peer support services to individuals in inpatient setting prior to discharge and after their return to their communities.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.

Since July 2019, SUD peer support services are a Medicaid reimbursable service. The Centers for Medicaid and Medicare approved Washington's State Plan Amendment to include SUD peer services as a reimbursable service June 2019. Since 7/1/2019 when we started asking people to self-identify on the CPC application until present, we have had a total of 1367 who either identify as SUD or co-occurring apply to become a CPC. Many individuals had completed the Recovery Coach training and as much as we like the message and values this provides; it does not require that people self-identify. In order to meet CMS requirements, DBHR offered a 'bridge' training for individuals who have completed Recovery Coach training to become a CPC. DBHR has conducted 8 of those training events.

The Housing and Recovery through Peer Services (HARPS) program is available to individuals with a substance use disorder who are exiting or at risk of entering inpatient behavioral health programs and who do not have access to Medicaid. HARPS provides participants with meaningful choice and control of housing and support services, using peer housing specialists. The HARPS project reduces homelessness and supports the recovery and resiliency of individuals with substance use disorder. HARPS provides permanent supportive housing services to individuals at risk of entering or exiting inpatient behavioral health services. HARPS also includes a shallow bridge subsidy to assist with rent, deposits, application fees etc..

An Oxford House is a live-in residence for people in recovery from substance use disorders. An Oxford House describes a democratically self-governed and self-supported drug-free house. In Washington, HCA's Division of Behavioral Health and Recovery (DBHR) is the state agency responsible for administering a revolving fund to initiate new Oxford Houses. Start-up house loans, for a maximum of $4,000 per house, are approved by Oxford House, Inc. and are paid back to DBHR's revolving fund over a two-year period. Washington boasts one of the largest numbers of Oxford Houses in the country with sites in 23 of the 39 counties within the state.

- As of April, 2023, we have 345 Oxford Houses and 3032 Beds available on a daily basis.
- Total Women's Houses are 101 and 43 of those Houses are for Women with Children.
- Total of Men's Houses are 244 and 24 of those Houses are for Men with Children.
- In the 345 Oxford Houses there are 276 houses and with 1,626 residents receiving Opioid Use Disorder Treatment.

In 2019, SHB1528 directed DBHR to create a Recovery Residence Registry based on the National Alliance for Recovery Residences. Recovery residences listed on the registry are verified by the Washington Alliance of Quality Recovery Residences (WAQRR) as following the National Alliance of Recovery Residences (NARR) best practices. These residences allow residents to use prescribed medication for physical health, mental health, and substance use disorders. An interactive map showing Oxford houses and Recovery Residences went live in early 2021. A revolving operating loan program using the Oxford model was also established and also went live.

As of May 2023, WAQRR has accredited an additional 35 homes for a total of 102 that have been approved to be on the HCA Recovery Residence Registry. There are currently 799 recovery residence beds in Washington state within these 102 accredited houses. WAQRR is in process of accrediting 64 additional homes that have submitted applications to be added to the HCA Recovery Residence Registry. WAQRR has scheduled training sessions toolkits to support community awareness and engagement and continues to provide technical assistance to new and established recovery residences to include in person and virtual training, webinars, and fidelity reviews.

In July of 2022, the HCA contracted with Pioneer Human Services to initiate an SUD Peer Bridger program. This program allowed for the hire of eight (8) additional Certified Peer Counselors to serve individuals transitioning from inpatient and/or residential settings to lower levels of care by providing peer supports, discharge planning, and goal setting during the transition process. To date, this program has supported 154 individuals.

The coming years will see the facilitation of many changes to Peer Support Services due to the passing of ESSB 5555 in May 2023. This legislation promotes the professionalization of peer services by making a Certified Peer Specialist license under the Department of Health in Washington State. The HCA will facilitate the necessary changes which will include 80 hours of training and 1500 hours of supervision in direct services for full licensure. HCA will also contract for the development of a peer supervisor training and the creation of a database which will link Peer Specialists with employers looking to hire. Current Certified Peer Counselors will need an additional 40 hours of training in order to qualify for the Peer Specialist license and the HCA will facilitate the training coordination efforts for this purpose.

Announced in 2003 as a three-year initiative to help Americans suffering from substance abuse and addiction, the SAMHSA funded Access to Recovery (ATR) program was so successful, it continued to be funded through three additional cohorts. ATR is client-directed, offers choice, and measures outcomes such as criminal justice involvement, education and employment, stability in housing, social connectedness, and abstinence. Washington received all four cohorts and the last grant ended January 31, 2019. ATR is no longer to be funded by SAMHSA but many of the recovery support services implemented by the ATR initiative had been sustained through SABG or State Opiate Response Grant funds.

One of the other programs funded under the State Opiate Response Grant is our Peer Pathfinder Program. Using CPCs who identify as having lived SUD or co-occurring mental health and SUD are conducting homeless outreach and engagement to individuals with suspected Opiate Use Disorders (OUD) or stimulant disorders. Twenty-eight Peer Pathfinders have been hired and are working closely with DBHR's Projects for Assistance in Transition from Homelessness (PATH) teams. Peer Pathfinders are also developing relationships with local emergency rooms to engage individuals who present with OUD overdose symptoms.

5. Does the state have any activities that it would like to highlight?

DBHR has developed Recovery Support Service Fact sheets that provide education, information and resources to individuals to promote a self-directed life and help individuals live to the greatest extent possible and strive to reach their full potential.

- Housing and Recovery through Peer Services (HARPS)
- Oxford house fact sheet
- Peer bridger
- Peer pathfinder project
- Peer respites
- Peer support services
- Program to Assist in the Transition from Homelessness (PATH)
- Recovery residences
- Social determinants of health-housing
- Supported employment 1115
- Housing First
- Homeless Outreach Stabilization Transition (HOST) Project
- Clubhouse and Peer Run Organizations
- Supporting Recovery in Community

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

Washington has proactively used SAMHSA sponsored policy academies to create strategic plans to improve housing and employment outcomes. DBHR would be interested in receiving technical assistance in developing a strategic plan to create an inventory of peer workforce needs and future opportunities to position CPC in various environments on the behavioral health services continuum. DBHR was fortunate to receive several Transformation Transition Initiative grants from NASHMPD – one specifically focused on creating a continuing education curriculum for peers working in crisis services. In conjunction with our four other continuing education curriculums (Peers providing supportive housing, peers providing supported employment, trauma informed approaches and working with individuals who have intersected with law enforcement) DBHR is interested in creating career pathways for peers.

Children and Adolescents M/SUD Services – Required for MHBG

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SUPTRS BG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.[1]. Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.[2]. For youth between the ages of 10 and 14 and young adults between the ages of 25 and 34, suicide is the second leading cause of death and for youth and young adults between 15 and 24, the third leading cause of death.[3].

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.[4].

Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.[5].

According to data from the 2017 Report to Congress[6] on systems of care, services:

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

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious M/SUD needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- *non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);*
- *supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and employment); and*
- *residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).*

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[1]Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).
[2]Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.
[3]Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.
[4]The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.
[5]Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from ***https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM***
[6] ***http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf***

Please respond to the following:

1. Does the state utilize a system of care approach to support:

a) The recovery of children and youth with SED?

Yes

b) The resilience of children and youth with SED?

Yes

c) The recovery of children and youth with SUD?

Yes

d) The resilience of children and youth with SUD?

Yes

2. **Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs**

a) Child welfare?

Yes

b) Juvenile justice?

Yes

c) Education?

Yes

d) Health Care

Yes

3**. Does the state monitor its progress and effectiveness, around:**

a) Service utilization?

Yes

b) Costs?

Yes

c) Outcomes for children and youth services?

Yes

4. **Does the state provide training in evidence-based:**

a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families?

Yes

b) Mental health treatment and recovery services for children/adolescents and their families?

Yes

5. **Does the state have plans for transitioning children and youth receiving services:**

a) to the adult M/SUD system?

Yes

b) for youth in foster care?

Yes

c) Is the child serving system connected with the FEP and Clinical High Risk for Psychosis (CHRP) systems?

Yes

d) Does the state have an established FEP Program?

Yes

e) Does the state have an established CHRP Program?

No

d) Is the state providing trauma informed care?

Yes

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

The Family Youth System Partner Round Table (FYSPRT) provides leadership to influence the establishment and sustainability of Children's Behavioral Health principles statewide. The Statewide and Regional FYSPRTs play a critical role, within the Child, Youth and Family. Behavioral Health Governance Structure, in informing and providing oversight for their communities and legislative-level policymaking, program planning, and decision-making.

Regional FYSPRTs serves as a mechanism for ensuring that local community input and the voice of families and youth with lived experience is present, participating in, and informing child, youth and family behavioral health. In alignment with the Children's Behavioral Health Principles, the Statewide and Regional FYSPRTs provide recommendations and strategies to improve behavioral health services, supports, and outcomes for children and youth and inform system transformation as well as review both process and outcome indicators including Wraparound with Intensive Services outcome and performance data. The FYSPRTs support System of Care values including:

1) Family and youth driven
2) Culturally and linguistically competent
3) Community-based

FYSPRTs also support the goals of the Washington State system of care:

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

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

- Contracting with Managed Care Organizations to maximize resources, have mechanisms for broader care coordination, and ensure that individuals have options for access to quality services.
- Partnership with Managed Care Organizations and their care coordinators to ensure that the needs of youth in complex, cross system situations are supported.
- Continued work within Health Care Authority toward full purchasing integration with physical and behavioral health services.
- Statewide implementation of Wraparound with Intensive Services (WISe) emphasizes a wraparound approach for the youth with complex behavioral health needs. WISe requires a team approach which includes certified peer counselor and utilization of the Child and Adolescent Needs and Strengths (CANS) assessment tool to evaluate needs and strengths in multiple domains as well as monitoring outcomes at the individual, agency, regional and state level.
- Roll out of Washington State's First Episode Psychosis Initiative, New Journeys placing emphasis on early intervention services for individuals experiencing early onset symptoms of schizophrenia. Currently, 11 programs are operational with a goal of statewide by October 2023.
- Family Peer Partner and Youth Peer Partner development in services and system development.
- As a part of our Washington Administrative Code (WAC) 388-877-0620 Clinical – Individual Service Plan outlines components required for mental health and substance use disorder treatment; including, but not limited to:

    - Address age, gender, cultural, strengths and/or disability issues identified by the individual or, if applicable, the individual's parent(s) or legal representative.

    - Use a terminology that is understandable to the individual and the individual's family.

    - Demonstrate the individual's participation in the development of the plan.

    - Document participation of family or significant others, if participation is requested by the individual and is clinically appropriate.

    - Be strength-based.

    - Contain measurable goals or objectives, or both.

The state has established collaborations with other child and youth serving agencies in the state to address behavioral health needs as evidenced by the coordinated contracts with Children's

Long Term Inpatient Program (CLIP) and regional Behavioral Health Administrative Service Organizations (BH-ASOs). This effort has been strengthened by the System of Care Grant and T.R. Settlement driven Children's Behavioral Health Governance Structure including the Children's Behavioral Health Executive Leadership Team, the Statewide FYSPRT, and ten Regional FYSPRTs. The Statewide FYSPRT has a tribal representative and representatives from youth and young adult serving state partners: Department of Children, Youth and Families (DCYF), which now includes Juvenile Rehabilitation (JR) and the Department of Early Learning (DEL), Department of Health (DOH),), Department of Health and Human Services (DSHS), Office of Superintendent of Public Instruction (OSPI), Developmental Disabilities Administration (DDA), Commerce, and Managed Care Organizations

Block Grant Funding has been used for several years to provide 'no cost' training and follow-up coaching to clinicians in Cognitive Behavioral Therapy Plus (CBT+). The dollars continue to support this work while in tandem developing a train-the-trainer model with the intention of placing local trainers in each Behavioral Health Organization to further grow the workforce." Block grant also funds the Washington State Institute for Public Policy (WSIPP) to update its list of evidence and research-based practices (ERBP's) on its web site.

Contracted Managed Care Organizations (MCO's) for both integrated managed care and integrated foster care are required to promote the use of ERBP's to their contracted behavioral health agencies and report to HCA how they promote the use of ERBP's in a culturally competent manner. Specific encounters of group, individual and family treatment sessions lasting more than 30 minutes have a code to indicate the use of an ERBP during that encounter. MCO's are required by contract to report how they are providing training and technical assistance to BHA's in the reporting of those ERBP's for children/youth.

Monitoring and tracking service utilization, costs, and outcomes for children and youth with mental, substance use, and co-occurring disorders are performed through many different methods. These include:

- Tracking evidence-based practice (EBP) reporting, and multiple input methods for WISe and CANs progress tracking.
- Following through the payment system (Provider One).
- Using performance-based contracting and contract monitoring.
- Monitoring Children's Behavioral Health Measures.

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

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

Prevention
Administered by the Washington State Office of Superintendent of Public Instruction (OSPI), federal Substance Abuse Prevention and Treatment block grant funds are awarded annually to regional Educational Service Districts. The Student Assistance Prevention Intervention Services program places Student Assistance Specialists in schools in Community Prevention and Wellness Initiative locations to address problems associated with substance use violence and other non-academic barriers to learning.
Student Assistance Specialists (SAP) are assigned to designated school sites to provide direct services to students who are at risk and/or harmfully involved with alcohol, tobacco, and other drugs. SAP services include:

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

7. **Does the state have any activities related to this section that you would like to highlight? (Please see above)**

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

Suicide Prevention

Suicide is a major public health concern, it is a leading cause of death overall, with over 47,000 people dying by suicide in 2021 in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges M/SUD agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with

SMI/SED who are at risk for suicide using MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the M/SUD agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following:

1. Have you updated your state's suicide prevention plan in the last 2 years?
No, the plan updates were underway but were postponed due to COVID. The last official update was in 2015.

2. Describe activities intended to reduce incidents of suicide in your state.

The State Strategic Prevention Enhancement Plan addresses suicide prevention and mental health promotion through the efforts of an interagency work group to address the goals set forth in the plan. In January 2016, Governor Inslee's Executive Order 16-02 on firearm fatality and suicide prevention, tasked several state agencies with addressing these issues.

Prevention Section:

Community-based organizations (CBOs) are state grant funded organizations that serve high-need communities by providing quality and culturally competent substance use disorder prevention and mental health promotion and suicide prevention programming through evidence-based, research-based, and innovative programs and strategies. CBOs can range from non-profits, faith-based organizations, educational service districts, schools, tribal or local governmental entities. CBOs are focused on the delivery of prevention and promotion programs and/or strategies to meet a targeted need. Such programs can include mentoring, parenting education, community awareness raising, training, and youth skill building.

CBOs and the programs they organize can support the larger Community Prevention and Wellness Initiative (CPWI) or other local or regional community coalitions of Washington State. Through partnerships like this, CBOs can help expand the reach of a coalition and build off their strategic plan. Alternately, CBOs can operate independently, providing targeted prevention and promotion programming to meet a need that organization has identified.
In January 2023, DBHR presented to the Governor for the Results WA Public Performance Review focus on suicide prevention. This presentation included information about the services and outcomes for the upstream suicide prevention efforts by HCA as well as our partner agencies Department of Health and Veteran's Affairs. Additional information and a video recording are available here: https://results.wa.gov/measuring-progress/public-performance-reviews.

3. Have you incorporated any strategies supportive of Zero Suicide?
Yes

4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments?
No

5. Have you begun any targeted or statewide initiatives since the FFY 2018 - 2019 plan was submitted?
Yes

If so, please describe the population targeted?
Emergency Response Suicide Prevention Grant: Adults over the age of 25, including victims of domestic violence. This grant was an 18-month grant and sunset in February of 2022.

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

Support of State Partners

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

- *The State Medicaid Authority agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations.*
- *The state's agency on aging which provides chronic disease self-management and social services critical for supporting recovery of older adults.*
- *The state's intellectual and developmental disabilities agency to ensure critical coordination for individuals with ID/DD and M/SUD conditions.*
- *Strong partnerships between SMHAs and SSAs and their counterparts in physical health, public health, and Medicaid, Medicare, state and area agencies on aging and educational authorities are essential for successful coordinated care initiatives. While the State Medicaid Authority (SMA) is often the lead on a variety of care coordination initiatives, SMHAs and SSAs are essential partners in designing, implementing, monitoring, and evaluating these efforts. SMHAs and SSAs are in the best position to offer state partners information regarding the most effective care coordination models, connect current providers that have effective models, and assist with training or retraining staff to provide care coordination across prevention, treatment, and recovery activities.*
- *SMHAs and SSAs can also assist the state partner agencies in messaging the importance of the various coordinated care initiatives and the system changes that may be needed for success with their integration efforts. The collaborations will be critical among M/SUD entities and comprehensive primary care provider organizations, such as maternal and child health clinics, community health centers, Ryan White HIV/AIDS CARE Act providers, and rural health organizations. SMHAs and SSAs can assist SMAs with identifying principles, safeguards, and*

enhancements that will ensure that this integration supports key recovery principles and activities such as person-centered planning and self-direction. Specialty, emergency and rehabilitative care services, and systems addressing chronic health conditions such as diabetes or heart disease, long-term or post-acute care, and hospital emergency department care will see numerous M/SUD issues among the persons served. SMHAs and SSAs should be collaborating to educate, consult, and serve patients, practitioners, and families seen in these systems. The full integration of community prevention activities is equally important. Other public health issues are impacted by M/SUD issues and vice versa. States should assure that the M/SUD system is actively engaged in these public health efforts.

- *SAMHSA seeks to enhance the abilities of SMHAs and SSAs to be full partners in implementing and enforcing MHPAEA and delivery of health system improvement in their states. In many respects, successful implementation is dependent on leadership and collaboration among multiple stakeholders. The relationships among the SMHAs, SSAs, and the state Medicaid directors, state housing authorities, insurance commissioners, prevention agencies, child-serving agencies, education authorities, justice authorities, public health authorities, and HIT authorities are integral to the effective and efficient delivery of services. These collaborations will be particularly important in the areas of Medicaid, data and information management and technology, professional licensing and credentialing, consumer protection, and workforce development.*

Please respond to the following items:

1. **Has your state added any new partners or partnerships since the last planning period?**
   Yes

2. **Has your state identified the need to develop new partnerships that you did not have in place?**
   Yes

If yes, with whom?

We have strengthened our relationship with multiple courts across the state as part of continued outreach and engagement in the Trueblood phased regions to aid court partners in the most efficient ways to access outpatient forensic specialty services and outpatient competency restoration and will continue to provide assistance to additional court partners.

We continue to deepen relationships with our partners in education, justice, disabilities administration, early learning, and child welfare. We have supported cross agency connection, coordination, and specialty teams working on different aspects of the lifespan to increase coordination, understand needs and systems of our partners, and have moved toward piloting and establishing new work cross agency through state and federal dollars, including programs like Youth Behavioral Health Navigators. Additionally, we're focusing on our partnership with our juvenile justice system and access and supports through Wrap Around with Intensive Services to support re-entry. We partner with several layers of the

educational system to increase access and to pilot access point to learn from and share such as the SAMHSA SOC grant funded Telehealth for schools playbook.

3. **Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilities Education Act.**
The Washington State Health Care Authority works with system partners to deliver services that promote successful transitions to and outcomes in community-based settings. Some examples are as follows:

   - HCA contracts with managed care organizations to provide robust care coordination services to ensure clients are successful in community-based settings. MCO care coordinators are required to work closely with clients, providers, and other State agencies to support access to medically necessary state plan services, waiver-based habilitative supports, and state-only funded wrap around services to ensure best possible outcomes for managed care enrolled clients.
   - Contractual requirements for MCOs and Behavioral Health Administrative Service Organizations require working as members of the state hospital Discharge Transition Team to identify potential discharge options and resolve barriers to discharge for assigned enrollees.
   - Each of the BH-ASOs works with stakeholders across their region to ensure coordination of services and resources. BH-ASOs sponsor monthly/quarterly provider meetings. BH-ASOs and providers participate in community events, and coordinate with the schools to provide outreach and support access to services. The BH-ASOs work with other state agencies including Developmental Disabilities Administration (DDA), Division of Youth and Families, and Home and Aging and Long-Term Services Administration. BH-ASOs also participate in monthly coordination meetings the HCA and bi-monthly coordination meetings with the Managed Care Organizations.
   - HCA contracts with community-based inpatient settings to provide behavioral health treatment for people on 90- or 180-day involuntary treatment orders. As part of these contracts, HCA expects the treatment settings to partner with the MCOs for Medicaid enrollees and BH-ASOs for people without Medicaid or outside of managed care, to assure complete discharge plans are in place for thoughtful transitions to lower levels of care.
   - Multi-System Rounds is a weekly meeting that pulls together a comprehensive team of subject matter experts, state agency leaders and Managed care organization clinical staff to assist youth (<21) who are at risk for dependency, institutionalization, or experiencing complex barriers to accessing community-based care. Health Care Authority is working to expand this program to address the needs of other populations.
   - Complex Discharge process reduces inpatient length of stay by ensuring MCOs are compliant with contract requirements for discharge planning and care coordination, identify and address barriers to discharge and implement solutions, with the goal of

minimizing or eliminating discharge barriers. MCOs are required to submit weekly reports on care coordination activities for all clients in the state who are clinically cleared for discharge.

- Cross agency escalation pathways have been established to address cases where there are barriers to individuals being served successfully in community-based settings.
- Intensive residential treatment (IRT) teams work with individuals discharging or diverting from state hospitals or long-term hospitalizations who need wraparound support. The teams help those struggling to remain in community settings such as adult family homes (AFH) or assisted living facilities. IRT teams are the primary mental health provider and use elements from assertive community treatment (ACT) to provide intensive wraparound mental health care to the individual in their facility, helping them transition to a lower level of care.
- Legislatively funded Difficult to Discharge Task Force pilot program is under development.
- HCA participates in DSHS-led client Critical Case Protocol (CCCP) meetings as needed for clients at risk of losing their community-based residential providers due to illegal activity, high utilization of emergency/law enforcement services, housing issues, or increased support needs.
- HCA's School-Based Health Care Services (SBHS) program provides Medicaid reimbursement to schools for evaluations, reevaluations, and direct health related services provided by qualified staff that are included in an eligible student's IEP. Public schools are required per the Individuals with Disabilities Education Act to find and evaluate students who may have disabilities, at no cost to families. If a child has a qualifying disability, schools must offer special education and related services (like speech therapy and counseling) to meet the child's unique needs through an Individualized Education Program (IEP). Schools are not required to participate in the SBHS program; however, participation benefits the entire school population as it brings in additional funding which helps offset costs associated with providing these healthcare related services.
- We support coordination and connection with our state Office of Superintendent of Public Instruction (OSPI) and our Medicaid office. Current conversations are underway to explore the gap between IDEA serving through age 21 and Medicaid EPSDT through age 20. Our legislature is interested in ensuring those supports stay intact while students are in K-12 services.
- We also partner with our Medicaid office and OSPI to identify pathways to support schools seeking to support access for behavioral health for their students, and are exploring areas like peers in schools, and supports for schools to support teachers so they can support students.
- HCA also contracts with the child and youth Children's Longterm Inpatient Program (CLIP) that consists of community based Psychiatric Residential Treatment Facilities (PRTF) and the hospital-based Child Study Treatment Center (CSTC) to ensure supports and coordination both prior to admission and as part of discharge coordination to ensure supports for community-based supports and services for the child and

family. Additionally, we contract with each program to ensure funding and support for familial/ natural support engagement during treatment in the CLIP program.

The Washington State Department of Social and Health Services works to support discharges to home and community, and delivers community based, person-centered services in community-based settings, including the following:

- Developmental Disabilities Administration:
- The Developmental Disabilities Administration (DDA) assists individuals with developmental disabilities and their families to obtain services and supports based on individual preference and capabilities and needs. DDA services help promote everyday activities, routines and relationships common to most citizens.
- Roads to Community Living is a demonstration project designed to help people with complex, long-term care needs move back into the community.
- Community Residential Services include both Alternative Living Services and Companion Home Services, which are provided in typical homes or apartments in the community.
- Home and community Services
- Home and Community Services (HCS) promotes, plans, develops and provides long-term care services for persons with disabilities and the elderly who may need state funds (Medicaid) to help pay for them.

State Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application – Required for MHBG

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in 42 U.S. C. 300x-3 for adults with SMI and children with SED. To meet the needs of states that are integrating services supported by MHBG and SUPTRS BG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as an Advisory/Planning Council (PC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a PC, SAMHSA has created ***Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.***[1]

Planning Councils are required by statute to review state plans and implementation reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as an advocate for individuals with M/SUD problems. SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council,

should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

- [1]***https://www.samhsa.gov/grants/block-grants/resources [samhsa.gov]***

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

1. **How was the Council involved in the development and review of the state plan and report? Attach supporting documentation (e.g., meeting minutes, letters of support, etc.)**
   The Behavioral Health Advisory Council (BHAC) was involved in the development and review of the state plan and report throughout the past year. To ensure ample time for thoughtful review and input, a copy of the FY2022-23 Block Grant application and priorities was submitted to BHAC for review in early December. The Block Grant Administrator then presented at the January meeting, reviewing in detail the Block Grant priorities and most recently reported outcomes submitted in the December 1st Block Grant Progress Report. The council formed workgroups to go over each priority before drafting final recommendations on the priorities they presented to DBHR leadership at the Advisory Council March meeting.

   The Block Grant team, along with input from DBHR leadership, reviewed the feedback provided by BHAC and incorporated some of the recommendations, including but not limited to priority 13 workforce innovations, and adding a focus on DEI for peers in priority 4, adjusting into the workplan and priorities documents created for the FY2024-25 application.

   At the July 2023 BHAC meeting, the Block Grant Administrator presented the draft priorities for the FY2024-25 Block Grant application. A second round of workgroups were formed by the council and compiled a final set of recommendations for the application that was sent to DBHR leadership in August 2023.

2. What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment, and recovery services?

Washington States planning council is integrated to address both mental health and substance misuse prevention, SUD treatment, and recovery services. The Behavioral Health Advisory Council sets aside multiple times on their yearly calendar to review and send recommendations to DBHR on the Block Grant application and its priorities. A Federal Block Grant Progress Report is presented at the January meeting. The Council then meets to identify needs and gaps in service and then sends written recommendations on the Federal Block Grant to DBHR at their March meeting. The Block Grant Administrator also presents a draft of the state's Block Grant priorities at the July meeting for the Council to review and comment on before the final application is submitted to SAMHSA.

Recommendations from the council, along with recommendations received by the Tribes during Tribal Listening Sessions, Roundtables and Tribal Councils, and recommendations

received during the public comment period are taken into consideration for identifying needs and gaps in service for substance misuse prevention, treatment and recovery services.

3. Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work?

Yes

4. Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?

Yes

5. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

The Behavioral Health Advisory Council (BHAC) was formed in 2012 and meets six times per year. Its membership is comprised of consumers and community members, including individuals with lived experience, family members or parents of children with SMI or SED, and Peer supports that represent the geographic and social diversity of the state with continued thoughtful recruitment efforts remaining under way to ensure representatives of tribal governments and other underrepresented communities are council seats reflective of the population served. The council also includes many partners and stakeholders from other state agencies including the Health Care Authority, Department of Corrections, Developmental Disabilities, Juvenile Rehabilitation, Department of Commerce-Housing, Department of Social and Health Services, the Office of the Superintendent of Public Instruction, as well as from regional Behavioral Health Organizations, Tribes, and providers. The Division of Behavioral Health and Recovery has utilized the collected group experience of the council to identify issues affecting service delivery and the impact of integration.

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

See next page for BHAC forms.

Behavioral Health Advisory Council Composition by Member Type

Advisory Council Composition by Member Type

Start Year: 2024 End Year: 2025

Type of Membership	Number	Percentage of Total Membership
Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	2	
Family Members of Individuals in Recovery (to include family members of adults with SMI)	3	
Parents of children with SED	3	
Vacancies (individual & family members)		
Others (Advocates who are not State employees or providers)	2	
Total Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services), Family Members and Others	**10**	**50.00%**
State Employees	9	
Providers	1	
Vacancies		
Total State Employees & Providers	**10**	**50.00%**
Individuals/Family Members from Diverse Racial and Ethnic Populations		
Individuals/Family Members from LGBTQI+ Populations		
Persons in recovery from or providing treatment for or advocating for SUD services	2	
Representatives from Federally Recognized Tribes	0	
Youth/adolescent representative (or member from an organization serving young people)	0	
Total Membership (Should count all members of the council)	**20**	

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Footnotes: