Washington

UNIFORM APPLICATION
FY 2022/2023 Combined MHBG ApplicationBehavioral Health Assessment and Plan

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

OMB - Approved 04/19/2019 - Expires 04/30/2022
(generated on 08/31/2021 12.22.23 PM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

and

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

State Information

State Information

Plan Year

Start Year	2022
End Year	2023

State SAPT DUNS Number

Number	7207571
Expiration Date	

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

Agency Name	Health Care Authority
Organizational Unit	Division of Behavioral Health and Recovery
Mailing Address	PO Box 42730
City	Olympia
Zip Code	98504

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

First Name	Michael
Last Name	Langer
Agency Name	Health Care Authority
Mailing Address	PO Box 42730
City	Olympia
Zip Code	98504
Telephone	360-725-9821
Fax	360-725-2280
Email Address	michael.langer@hca.wa.gov

State CMHS DUNS Number

Number	7207571
Expiration Date	

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

Agency Name	Health Care Authority
Organizational Unit	Division of Behavioral Health and Recovery
Mailing Address	PO Box 42730
City	Olympia
Zip Code	98504

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

First Name	Keri
Last Name	Waterland
Agency Name	Health Care Authority

Mailing Address PO Box 42730

City Olympia

Zip Code 98504-2730

Telephone 360-725-5252

Fax 360-725-2280

Email Address keri.waterland@hca.wa.gov

III. Third Party Administrator of Mental Health Services

Do you have a third party administrator? ○ Yes ○ No

First Name

Last Name

Agency Name

Mailing Address

City

Zip Code

Telephone

Fax

Email Address

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

From

To

V. Date Submitted

Submission Date 8/31/2021 12:16:46 PM

Revision Date 8/31/2021 12:17:07 PM

VI. Contact Person Responsible for Application Submission

First Name Janet

Last Name Cornell

Telephone 360-725-0859

Fax 360-725-2280

Email Address janet.cornell@hca.wa.gov

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

State Information

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

Fiscal Year 2022

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

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1921	Formula Grants to States	**42 USC § 300x-21**
Section 1922	Certain Allocations	**42 USC § 300x-22**
Section 1923	Intravenous Substance Abuse	**42 USC § 300x-23**
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	**42 USC § 300x-24**
Section 1925	Group Homes for Recovering Substance Abusers	**42 USC § 300x-25**
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	**42 USC § 300x-26**
Section 1927	Treatment Services for Pregnant Women	**42 USC § 300x-27**
Section 1928	Additional Agreements	**42 USC § 300x-28**
Section 1929	Submission to Secretary of Statewide Assessment of Needs	**42 USC § 300x-29**
Section 1930	Maintenance of Effort Regarding State Expenditures	**42 USC § 300x-30**
Section 1931	Restrictions on Expenditure of Grant	**42 USC § 300x-31**
Section 1932	Application for Grant; Approval of State Plan	**42 USC § 300x-32**
Section 1935	Core Data Set	**42 USC § 300x-35**
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	**42 USC § 300x-51**
Section 1942	Requirement of Reports and Audits by States	**42 USC § 300x-52**

Section 1943	Additional Requirements	**42 USC § 300x-53**
Section 1946	Prohibition Regarding Receipt of Funds	**42 USC § 300x-56**
Section 1947	Nondiscrimination	**42 USC § 300x-57**
Section 1953	Continuation of Certain Programs	**42 USC § 300x-63**
Section 1955	Services Provided by Nongovernmental Organizations	**42 USC § 300x-65**
Section 1956	Services for Individuals with Co-Occurring Disorders	**42 USC § 300x-66**

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions

to State (Clear Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
    a. Checking the Exclusion Extract located on the System for Award Management (SAM) at http://sam.gov
    b. Collecting a certification statement similar to paragraph (a)
    c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work place in accordance with 2 CFR Part 182 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
    1. The dangers of drug abuse in the workplace;
    2. The grantee's policy of maintaining a drug-free workplace;
    3. Any available drug counseling, rehabilitation, and employee assistance programs; and
    4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
    1. Abide by the terms of the statement; and
    2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
    1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
    2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

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

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

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

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

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

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

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

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

State: ____

Name of Chief Executive Officer (CEO) or Designee: ____

Signature of CEO or Designee[1]: ____

Title: ____ Date Signed: ____

mm/dd/yyyy

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

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

JAY INSLEE
Governor

STATE OF WASHINGTON
Office of the Governor

April 26, 2018

Wendy Pang
Grants Management Specialist
Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1091
Rockville, MD 20857

Dear Ms. Pang:

Washington State has a long history of implementing significant and innovative initiatives related to integration and care coordination. As of July 1, 2018, the Division of Behavioral Health and Recovery will transfer from the Department of Social and Health Services (DSHS) to the Health Care Authority (HCA) in order to fully integrate behavioral health and physical health care services.

This change requires the transition of the oversight, both financial and programmatic, of the Substance Abuse and Mental Health Services Administration grants from DSHS to HCA. Therefore, I am designating Susan E. Birch, Director of HCA, as the signature authority related to the Unified Block Grant for the Substance Abuse Block Grant and Mental Health Block Grant, the Projects for Assistance in Transition from Homelessness Grant as well as any other discretionary grants. This authority includes the signing of any standard federal forms such as Assurances, Certifications, and Disclosure of Lobbying Activities. In addition, I am designating HCA Director Susan E. Birch as the Single State Authority for Washington State.

The grants affected by this transition are listed in the enclosed document, which includes the Data Universal Numbering System (DUNS) number, Employer Identification Number and agency mailing address for each grant.

Thank you for your attention to this matter.

Very truly yours,

Jay Inslee
Governor

Enclosure

cc: Cheryl Strange, DSHS Secretary
Susan E. Birch, MBA, BSN, RN, HCA Director

Division of Behavioral Health and Recovery
Federal Grant Listing

Grant Number	FAIN	CFDA #	Grant Name	DUNS	EIN	Agency Name	Agency Address
5U79SP020155	SP020155	93.243	Strategic Prevention Framework Partnerships for Success	007207571	91-1412780	Health Care Authority	PO Box 45502 Olympia, WA 98504-5502
5H79TI025995	TI025995	93.243	CSAT State Youth Treatment - Implementation	007207571	91-1412780	Health Care Authority	PO Box 45502 Olympia, WA 98504-5502
6H79SM061705	SM061705	93.243	Becoming Employed Start Today	007207571	91-1412780	Health Care Authority	PO Box 45502 Olympia, WA 98504-5502
5H79TI026138	TI026138	93.243	MAT-PDOA Project	007207571	91-1412780	Health Care Authority	PO Box 45502 Olympia, WA 98504-5502
1H79TI025570	TI025570	93.243	Access to Recovery	007207571	91-1412780	Health Care Authority	PO Box 45502 Olympia, WA 98504-5502
5H79SP022135	SP022135	93.243	Prevent Prescription Drug/Opioid Overdose-Related Deaths	007207571	91-1412780	Health Care Authority	PO Box 45502 Olympia, WA 98504-5502
1H79TI080249	TI080249	93.788	WA-STR addresses the Opiate Epidemic by increasing treatment & Prevention	007207571	91-1412780	Health Care Authority	PO Box 45502 Olympia, WA 98504-5502
2B09SM010056	SM010056	93.958	Mental Health Services Block Grant	007207571	91-1412780	Health Care Authority	PO Box 45502 Olympia, WA 98504-5502
2B08TI010056	TI010056	93.959	Substance Abuse Prevention and Treatment Block Grant	007207571	91-1412780	Health Care Authority	PO Box 45502 Olympia, WA 98504-5502
2X06SM016048	SM016048	93.150	Projects for Assistance in Transition from Homelessness	007207571	91-1412780	Health Care Authority	PO Box 45502 Olympia, WA 98504-5502

STATE OF WASHINGTON
HEALTH CARE AUTHORITY
626 8th Avenue, SE • P.O. Box 45502 • Olympia, Washington 98504-5502

May 17, 2019

Ann Piesen
Senior Grants Policy Advisor
Division of Grants Management
SAMHSA
5600 Fishers Lane
Rockville, MD 20857

Dear Ms. Piesen:

I hereby delegate to the Assistant Director of the Division of Behavioral Health and Recovery (DBHR) of the Washington State Health Care Authority (HCA), the authority to act on my behalf in making application, reports (including Synar), and certifications related to the Unified Block Grant for the Substance Abuse Block Grant, the Mental Health Block Grant, the Projects for Assistance in Transition from Homelessness Grant, as well as any other discretionary grants administered by the HCA.

This delegation of signatory authority is for the person who holds the office of the Assistant Director of DBHR. The current Assistant Director of DBHR is Keri L. Waterland. This authority shall transfer to any and all individuals who are appointed Assistant Director of DBHR during my tenure as Director of HCA.

This delegation of authority is effective May 1, 2019. This delegation shall apply to any requirements for release of funds and other assistance necessary to implement or manage the grant process.

Your assistance with this matter is appreciated.

Sincerely,

Susan E. Birch, MBA, BSN, RN
Director

cc: Megan Atkinson, Chief Financial Officer, FS, HCA
Keri L. Waterland, Assistant Director, DBHR, HCA
Annette Schuffenhauer, Assistant Director, DLS, HCA
Janet Cornell, Block Grant Administrator, DBHR, HCA
Melodie Pazolt, PATH State Contact, DBHR, HCA

State Information

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

Fiscal Year 2022

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and
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Section 1935	Core Data Set	42 USC § 300x-35
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
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Section 1943	Additional Requirements	**42 USC § 300x-53**
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As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
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LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
    a. Checking the Exclusion Extract located on the System for Award Management (SAM) at http://sam.gov
    b. Collecting a certification statement similar to paragraph (a)
    c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work place in accordance with 2 CFR Part 182 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
    1. The dangers of drug abuse in the workplace;
    2. The grantee's policy of maintaining a drug-free workplace;
    3. Any available drug counseling, rehabilitation, and employee assistance programs; and
    4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
    1. Abide by the terms of the statement; and
    2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
    1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
    2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

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

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

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

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

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

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

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

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

State: Washington

Name of Chief Executive Officer (CEO) or Designee: Keri L. Waterland

Signature of CEO or Designee[1]:

Title: Director for the Division of Behavioral Health and Recovery

Date Signed: 8/5/2021

mm/dd/yyyy

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

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

State Information

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

Fiscal Year 2022

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

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1911	Formula Grants to States	**42 USC § 300x**
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	**42 USC § 300x-1**
Section 1913	Certain Agreements	**42 USC § 300x-2**
Section 1914	State Mental Health Planning Council	**42 USC § 300x-3**
Section 1915	Additional Provisions	**42 USC § 300x-4**
Section 1916	Restrictions on Use of Payments	**42 USC § 300x-5**
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    2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
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f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
    1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
    2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

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

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

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

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

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

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

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

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

Name of Chief Executive Officer (CEO) or Designee: ______________________________

Signature of CEO or Designee[1]: ______________________________

Title: ______________________________ Date Signed: ______________________________

mm/dd/yyyy

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

Please upload the states American Rescue Plan funding proposal here in addition to the other documents.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

State Information

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

Fiscal Year 2022

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

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1911	Formula Grants to States	**42 USC § 300x**
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	**42 USC § 300x-1**
Section 1913	Certain Agreements	**42 USC § 300x-2**
Section 1914	State Mental Health Planning Council	**42 USC § 300x-3**
Section 1915	Additional Provisions	**42 USC § 300x-4**
Section 1916	Restrictions on Use of Payments	**42 USC § 300x-5**
Section 1917	Application for Grant	**42 USC § 300x-6**
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	**42 USC § 300x-51**
Section 1942	Requirement of Reports and Audits by States	**42 USC § 300x-52**
Section 1943	Additional Requirements	**42 USC § 300x-53**
Section 1946	Prohibition Regarding Receipt of Funds	**42 USC § 300x-56**
Section 1947	Nondiscrimination	**42 USC § 300x-57**
Section 1953	Continuation of Certain Programs	**42 USC § 300x-63**
Section 1955	Services Provided by Nongovernmental Organizations	**42 USC § 300x-65**
Section 1956	Services for Individuals with Co-Occurring Disorders	**42 USC § 300x-66**

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to

State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
    a. Checking the Exclusion Extract located on the System for Award Management (SAM) at http://sam.gov
    b. Collecting a certification statement similar to paragraph (a)
    c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
    1. The dangers of drug abuse in the workplace;
    2. The grantee's policy of maintaining a drug-free workplace;
    3. Any available drug counseling, rehabilitation, and employee assistance programs; and
    4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
    1. Abide by the terms of the statement; and
    2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
    1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
    2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

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

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
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HHS Assurances of Compliance (HHS 690)

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The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
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The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

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

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

Name of Chief Executive Officer (CEO) or Designee: Keri L. Waterland

Signature of CEO or Designee[1]:

Title: Director for the Division of Behavioral Health and Recovery

Date Signed: 08/05/2021

mm/dd/yyyy

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

Please upload the states American Rescue Plan funding proposal here in addition to the other documents.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

JAY INSLEE
Governor

STATE OF WASHINGTON
Office of the Governor

April 26, 2018

Wendy Pang
Grants Management Specialist
Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1091
Rockville, MD 20857

Dear Ms. Pang:

Washington State has a long history of implementing significant and innovative initiatives related to integration and care coordination. As of July 1, 2018, the Division of Behavioral Health and Recovery will transfer from the Department of Social and Health Services (DSHS) to the Health Care Authority (HCA) in order to fully integrate behavioral health and physical health care services.

This change requires the transition of the oversight, both financial and programmatic, of the Substance Abuse and Mental Health Services Administration grants from DSHS to HCA. Therefore, I am designating Susan E. Birch, Director of HCA, as the signature authority related to the Unified Block Grant for the Substance Abuse Block Grant and Mental Health Block Grant, the Projects for Assistance in Transition from Homelessness Grant as well as any other discretionary grants. This authority includes the signing of any standard federal forms such as Assurances, Certifications, and Disclosure of Lobbying Activities. In addition, I am designating HCA Director Susan E. Birch as the Single State Authority for Washington State.

The grants affected by this transition are listed in the enclosed document, which includes the Data Universal Numbering System (DUNS) number, Employer Identification Number and agency mailing address for each grant.

Thank you for your attention to this matter.

Very truly yours,

Jay Inslee
Governor

Enclosure

cc: Cheryl Strange, DSHS Secretary
Susan E. Birch, MBA, BSN, RN, HCA Director

Division of Behavioral Health and Recovery
Federal Grant Listing

Grant Number	FAIN	CFDA #	Grant Name	DUNS	EIN	Agency Name	Agency Address
5U79SP020155	SP020155	93.243	Strategic Prevention Framework Partnerships for Success	007207571	91-1412780	Health Care Authority	PO Box 45502 Olympia, WA 98504-5502
5H79TI025995	TI025995	93.243	CSAT State Youth Treatment - Implementation	007207571	91-1412780	Health Care Authority	PO Box 45502 Olympia, WA 98504-5502
6H79SM061705	SM061705	93.243	Becoming Employed Start Today	007207571	91-1412780	Health Care Authority	PO Box 45502 Olympia, WA 98504-5502
5H79TI026138	TI026138	93.243	MAT-PDOA Project	007207571	91-1412780	Health Care Authority	PO Box 45502 Olympia, WA 98504-5502
1H79TI025570	TI025570	93.243	Access to Recovery	007207571	91-1412780	Health Care Authority	PO Box 45502 Olympia, WA 98504-5502
5H79SP022135	SP022135	93.243	Prevent Prescription Drug/Opioid Overdose-Related Deaths	007207571	91-1412780	Health Care Authority	PO Box 45502 Olympia, WA 98504-5502
1H79TI080249	TI080249	93.788	WA-STR addresses the Opiate Epidemic by increasing treatment & Prevention	007207571	91-1412780	Health Care Authority	PO Box 45502 Olympia, WA 98504-5502
2B09SM010056	SM010056	93.958	Mental Health Services Block Grant	007207571	91-1412780	Health Care Authority	PO Box 45502 Olympia, WA 98504-5502
2B08TI010056	TI010056	93.959	Substance Abuse Prevention and Treatment Block Grant	007207571	91-1412780	Health Care Authority	PO Box 45502 Olympia, WA 98504-5502
2X06SM016048	SM016048	93.150	Projects for Assistance in Transition from Homelessness	007207571	91-1412780	Health Care Authority	PO Box 45502 Olympia, WA 98504-5502

STATE OF WASHINGTON
HEALTH CARE AUTHORITY
626 8th Avenue, SE • P.O. Box 45502 • Olympia, Washington 98504-5502

May 17, 2019

Ann Piesen
Senior Grants Policy Advisor
Division of Grants Management
SAMHSA
5600 Fishers Lane
Rockville, MD 20857

Dear Ms. Piesen:

I hereby delegate to the Assistant Director of the Division of Behavioral Health and Recovery (DBHR) of the Washington State Health Care Authority (HCA), the authority to act on my behalf in making application, reports (including Synar), and certifications related to the Unified Block Grant for the Substance Abuse Block Grant, the Mental Health Block Grant, the Projects for Assistance in Transition from Homelessness Grant, as well as any other discretionary grants administered by the HCA.

This delegation of signatory authority is for the person who holds the office of the Assistant Director of DBHR. The current Assistant Director of DBHR is Keri L. Waterland. This authority shall transfer to any and all individuals who are appointed Assistant Director of DBHR during my tenure as Director of HCA.

This delegation of authority is effective May 1, 2019. This delegation shall apply to any requirements for release of funds and other assistance necessary to implement or manage the grant process.

Your assistance with this matter is appreciated.

Sincerely,

Susan E. Birch, MBA, BSN, RN
Director

cc: Megan Atkinson, Chief Financial Officer, FS, HCA
Keri L. Waterland, Assistant Director, DBHR, HCA
Annette Schuffenhauer, Assistant Director, DLS, HCA
Janet Cornell, Block Grant Administrator, DBHR, HCA
Melodie Pazolt, PATH State Contact, DBHR, HCA

State Information

Disclosure of Lobbying Activities

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

Name

Title

Organization

Signature: Date:

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Planning Steps

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

Narrative Question:

Provide an overview of the state's M/SUD prevention, early identification, treatment, and recovery support systems of care, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD system of care 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. The description should also include how these systems of care address the needs of diverse racial, ethnic, and sexual and gender minorities, as well as American Indian/Alaskan Native populations in the states.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Washington State Health Care Authority

Washington

UNIFORM APPLICATION
FY 2022/2023 – 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

Division of Behavioral Health and Recovery
FFY22-FFY23 Block Grant Application
September 1, 2021

ASSESS THE STRENGTH AND NEEDS OF THE BEHAVIORAL HEALTH SYSTEM

Provide an overview of the state's M/SUD 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.

The description should also include how these systems address the needs of diverse racial, ethnic, and sexual and gender minorities, as well as American Indian/Alaskan Native populations in the states.

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, 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
- Intervention
- 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
- Pathological and problem gambling services

DBHR manages many funding sources that support the majority of 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 RDA, DBHR 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, 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.

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 2020:

- 48,298 clients participated in substance use disorder treatment.
- 13,592 clients received direct services through substance use disorder prevention activities.
- 2,189 youth received SUD outpatient treatment services.
- 197,364 adults with serious mental illness received outpatient mental health treatment services.
- 417 peers received Certified Peer Counseling (CPC) training through the Peer Support Program.
- 4,437 enrollments in Supported Employment services.
- 5,199 enrollments in Supportive Housing services.
- Nine coordinated care sites in seven regional service areas serving youth experiencing first episode psychosis. As of September 2020, the nine sites have 137 Active clients, and 49 clients have graduated from the program. Since New Journeys has started, the clinicians across the state have provided services to 318 people.
- Peer Pathfinders utilized block grant funding to build and sustain the workforce by creating a Homeless Outreach Academy with an enrollment number of 205.
- 1,813 pregnant and parenting women received case management services.

Total BHA expenditures in SFY 2020: approximately $2.093 billion distributed as follows:

- Community Mental Health (MH): $1.02 billion
- Community Substance Use Disorder (SUD) treatment: $515 million
- State Psychiatric Hospitals: $558.68 million

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:
    - Homeless or inappropriately housed
    - Involved with the criminal justice system
    - Living in rural or frontier areas of the state
- Members of traditionally underserved, including:
    - American Indian/Alaska Native population
    - Other Racial/ethnic minorities
    - LGBTQIA populations
    - 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; proviso funding such as Designated Marijuana 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 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.

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).

American Indian/Alaska Natives

Effective July 1, 2017, the AI/AN population has the option of receiving mental health and substance use disorder treatment through the Medicaid managed care system or choose to receive their services through a fee-for-service delivery system.

In Washington, individuals who self-identify as American Indian/Alaska Native (AI/AN) and are Medicaid enrollees are exempt from the integration of behavioral health treatment (SUD and MH) services provided by managed care programs. The exemption for substance use treatment began in April 2016 and then expanded to mental health in July 2017. The exemption of behavioral health services from managed care for AI/AN individuals was in response to concerns expressed by the Washington State Tribes and Urban Indian Health Organizations, as well as in collaboration with the Centers for Medicaid and Medicare Services (CMS). 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.

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
- Tribal governments and other tribal partners

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. The Division of Behavioral Health and Recovery (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
- 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

SAMHSA Block Grants and other grant programs are important drivers in supporting Washington State and DBHR 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 with Tribal governments through a consultation process. The INA has an umbrella agreement that includes the general terms and conditions. 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 these various funding resource 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 scope of work. As an example, HCA will use 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 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.

HCA negotiated through the INAs a monitoring schedule and agreed to desk monitoring reviews on a biannual basis. All Tribal governments participate in the annual single audit and HCA monitors these findings through the desk review and annual review process.

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.

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 including the Tribal Behavioral Health Conference hosted by the North Sounds BH-ASO and the North Sound Region Tribes, Kalispel Tribe's Tree of Healing Conference, Tribal Prevention Gathering.
- 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. 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

HCA/DBHR 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.

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).

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.

Most services provided are structured evidence-based drug and alcohol 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. 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. DBHR 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 marijuana 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.

DBHR 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.

DBHR 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. The current system is set to expire over the next year and the funds provided through block grant will aid in the development of the new system. Funds will support enhancements to the reporting system that the current system does not currently capture.

DBHR 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. DBHR 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.

ADULT BEHAVIORAL HEALTH SYSTEM

Mental Health

As of January 1, 2020, all regions of Washington state have made 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.

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. 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. 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.

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

The FIMCs, and BHOs through contracts with community substance use disorder agencies, provide a complete array of quality treatment services to 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 BHO's contract with provider groups and community substance use disorder agencies. Each BHO and FIMC serves all Medicaid enrollees within its geographical area except for AI/AN who have opted out of receiving SUD services through the BHOs but 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 and education. 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 who are addicted to substances and their families. There are currently 69 intensive inpatient residential providers with a total capacity of 2,146 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 seven adult long-term residential providers with a total capacity of 135 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.

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 vivitrol. 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 are 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 are clinically managed residential facilities that have limited medical coverage. 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.

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:

- Legislative direction for movement to fully integrated purchasing region with a multi staged integration from 2016 and ending with the final regions in 2020.
- 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. Access to Care Standards highlights the need to evaluate functional need in all domains.
- Washington State's First Episode Psychosis Initiative, 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.
- As a part of our Washington Administrative Code 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 Service Organizations. 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 these six youth-serving state partners: Rehabilitation Administration-Juvenile Rehabilitation (RA), Department of Health (DOH), Children's Administration (CA), Health Care Authority (HCA), Office of Superintendent of Public Instruction (OSPI), and Developmental Disabilities Administration (DDA).

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 are required to implement at least 15 percent Evidence/Research-Based Programs and/or Practices (EBPPs) into the Behavioral Health Organization contracts for children/youth. The required percentage increases yearly with 2017 contractual requirements ending at 30 percent. The intention is steadily increasing the percentage of EBPP services for children and youth 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.

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.

AN OVERVIEW OF THE CONTINUUM OF CARE

DBHR includes services and program support for behavioral health, prevention/promotion, and early intervention, 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 new 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 will become Designated Crisis Responders and will 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. RCW 70.96A and the role and functions of the Designated Chemical Dependency Specialist will expire April 1, 2018.

If an AI/AN who is served by a tribal behavioral health provider is in crisis, DBHR requires that the BHOs 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.

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 Dep. 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.

Pregnant Women and Women with Dependent Children

Pregnant and Parenting Women (PPW) 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 PPW Substance Use Disorder Outpatient Treatment Services, PPW Substance Use Disorder Residential Treatment Services, PPW 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).

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 Consumer Partnership

The Office of Consumer Partnership (OCP) currently has a team of twelve who have various types of experience/perspectives as individuals with lived experience of behavioral health systems in the state. The members provide a voice for children and adults receiving mental health and substance use disorder treatment services. The OCP is a priority within DBHR with a clearly defined purpose. Some key elements include:

- Providing leadership as a member of the Executive Management Team.
- Advocating for both substance use disorder and mental health individuals with lived experience.
  - Ensuring, by policy and contractual requirements, that advisory committees and planning groups include meaningful consumer voice.
- Assisting in the development and support of emerging consumer leadership.
- Supporting consumer networking and leadership training at DBHR-supported conferences and trainings.
- Assisting with recovery-oriented training, including Mental Health First Aid and Wellness Recovery Action Plan training.
- Promoting recovery values statewide through DBHR leadership and involvement in behavioral health systems and the community.
- Entering into a new relationship with the State Board of Community and Technical Colleges.

- 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.

WORKFORCE DEVELOPMENT

Tribal Behavioral Health Conference

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

- Tree of Healing Conference hosted by the Kalispel Tribe of Indian 2020 & 2021
- Wrap-Around with Intensive Services (WISe) curriculum training adaptation for Tribal communities 2019 - 2021
- Trauma Informed Approaches training specific for Tribal and AI/AN communities 2020-2021
- Youth Marijuana Prevention Training, 2021
- Tribal Certified Peer Counselor training (2) and training of trainer 2021-2022
- Treatment data encounter system on the TARGET data system trainings in 2019 provided to 8 tribes across the state for professional staff and data entry staff. HCA assisted 2 tribes get back into TARGET so data could be caught up and the tribes current with their SUD treatment information.
- Prevention services encounter reporting for all Tribes implementing prevention services to appropriately capture prevention service by CSAP and IOM strategy.

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.

Co-Occurring Disorder Conference

The annual Washington State COD and Treatment Conference will be held virtually this year due to COVID on October 4th and 5th, 2021. Ethics and Suicide Prevention will be provided on October 3rd, 2021.
The conference provides attendees (including consumer and family) with information regarding current legislation related to mental health care and services, current resources, and treatment methodologies.

This year, the COD conference plenary sessions focus on reconnecting after the pandemic, trans youth mental health, and new research into psychedelics as a treatment. In addition to the plenary focus areas the conference will also have workshops addressing, Trauma, Medication Assisted Therapies, youth and gender issues, special populations, 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. This year's Conference theme was "Stronger Together: A Path Forward" and was held virtually due to COVID June 16-18, 2021. With plans to resume in person conferences in 2022, once it is safe to do so (if in-person isn't possible in 2022, it will be held virtually).

The conference included 35 workshops, with tracks on Recovery & Resiliency, Evidence-Based, Best & Promising Practices, Race & Equity in Behavioral Health, Corrections & Mental Health, Management, Leadership & Operations, and two general Services & Partnerships tracks. Keynote speakers included Victor Armstrong, MSW, speaking on stigma, mental health, and suicide in historically marginalized communities; Debra A. Pinals, MD, focused on bringing recovery principles into correctional settings; Nic Sheff shared his wrenching story of substance abuse, mental illness, and recovery; and Allison Massari, a trauma survivor and leading healthcare educator, addressed compassion fatigue and patient-centered care. There were 687 attendees in 2021, including consumers, consumer advocates, members of the Behavioral Health Advisory Council, family members, clinical staff from community providers including behavioral health agencies, substance use disorder providers, staff of BH-ASOs, MCOs, state agencies including HCA, DSHS, DOC, DCYF, DVR, and many more stakeholders.

Saying It Out Loud Conference

The Saying it Out Loud (SIOL) Conference is planned in partnership with the Lesbian, Gay, Bisexual, Transgender, Queer (LGBTQ+) 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 the diverse fields of social work, mental health, substance use disorder treatment, substance abuse prevention, physical healthcare etc. to learn and improve the health and well-being of LGBTQ+ 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 LGBTQ+ communities, community providers, and state agencies to better support and care for individuals who identify as LGBTQ+.

This year's conference was held virtually on Wednesday May 26th, 2021. There were approximately 450 participants in attendance from around the state of Washington. The Keynote, Justice G. Helen Whitener shared her background and being the first Black woman to serve on the Washington Supreme Court, the fourth immigrant born Justice and the first Black LGBT judge in the State of Washington. Justice Whitener spoke on human rights, access to justice, and the responsibility of the judiciary to ensure the right of all who appear before the court to basic dignity and respect in judicial proceedings.

Workshops were offered to increase and encourage awareness, communication, and improve service delivery for LGBTQ+ individuals of all ages. Community providers and agencies throughout the state also attended as exhibitors to share information and resources.

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, providing the highest quality of care, with the health and wellbeing of LGBTQ+ individuals in mind.

Prevention Summit and Youth Forum

The annual Washington State Prevention Summit (Summit) provides an enriching and culturally competent training and networking opportunity for youth, volunteers, and professionals working toward the prevention of substance use disorder. The two-day conference event includes high-quality workshops, forums, and hands-on learning opportunities to meet a variety of needs, including professional development for prevention providers. Specifically, the Summit provides education and training to prevent alcohol, tobacco, marijuana, and opioid misuse and abuse. 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 (ages 12-18). Youth learn relevant skills in the following topic areas self-development, peer relationships, drug refusal skills and strategies to strengthen personal commitment against substance use. Youth are encouraged to develop their identities as leaders and explore how they can be catalysts for meaningful community-level change.

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.

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 4 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 for 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.

Since 2005, the Peer Support Program has certified 4789 Certified Peer Counselors. Between July 1, 2019, and June 30, 2020, the Peer Support Program certified 458 Certified Peer Counselors, this number was affected by COVID-19 during the transition to virtual trainings. Between 7/1/2020 and early May 2021 the Peer Support Program has certified 476 Certified Peer Counselors. Since July of 2019, 343 peers who identify as either having substance use or co-occurring recovery have become Certified Peer Counselors.

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. We currently sponsor this training 4 times a year.

The Peer Support Program is in process of creating several additional continuing education online trainings that will be available to all CPCs building upon the supportive housing, supported employment and trauma informed approach online curriculums. We are actively working on an online Certified Peer Counselor Crisis Services training that was funded through a NASHMD Transformation Technology Information grant. This training will be used to provide continuing education to all CPCs in Washington State and specifically to CPCs who will be working in the crisis system.

The continuing education training "The Intersection of Behavioral Health and the Law" was developed out of the Trueblood Lawsuit to provide continuing education to CPCs on how best to support people who are involved in the criminal court system. That training curriculum is currently being transitioned into an online LMS type training. In addition to these two trainings, DBHR is working on an online CPC Documentation and an online CPC Ethics and

Boundaries training. Links to these trainings will be added to our current list of available online trainings. Our current online trainings include Trauma Informed Approach, Supported Employment, and Supportive Housing.

In addition to the online trainings, we were able to fund two virtual Intentional Peer Support Trainings for peers.

Technical Assistance to Agencies

Technical assistance training is made available to behavioral health agencies who are interested in adding Peer Services to their book of business. Operationalizing Peer Support is funded through both MHBG and SABG and is offered at no cost to agencies. Technical assistance is tailored to the needs of each organization and may include topics such as peer services implementation, hiring practices, supervision, or documentation.

Additional Workforce Continuing Education and Technical Assistance

In 2020, DBHR held the 5th Annual Peer Pathways Workforce Development Conference. Due to COVID-19 the conference was transitioned to a virtual format and was a great success. There were 397 people who registered for the conference. We are currently planning the 6th Annual Peer Pathways Conference that will also be held virtually in response to COVID-19. 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.

To meet the increasing demand for training, DBHR provides quarterly train the trainer events. We have created a training pathway through a mentoring toolkit, the toolkit includes core competencies for trainers and a system for coaching. DBHR utilized these train the trainer events to not only increase the number of approved trainers but to mentor other trainer and training organizations on how to effectively host virtual trainings.

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 2 tribal specific trainings and 2 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.

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 6 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 plans to transition back to in person trainings for the bulk of our events, however DBHR will continue to offer our certification trainings in a virtual format throughout the year.

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:

Washington State Targeted Response to the Opioid Crisis (WA-STR)

May 1, 2017 through May 30, 2019

The WA-Opioid STR Project is designed to address the state's opioid epidemic by implementing four major goals: add five new Community Prevention Wellness Initiatives sites; increase prescriber/consumer education, complete an evidenced-based practice analysis, and implement a statewide public education campaign; 2) Treatment/Recovery Support- implement six Hub and Spoke Projects, provide a minimum of five MOUD trainings, design/implement a Substance Use Disorder Peers initiative, increase treatment access with financial hardship initiative, reduce correctional recidivism for adults and juveniles, develop a low-barrier Buprenorphine pilot to increase treatment access, engage a minimum of five tribes to design a tribal treatment information campaign and operate Mobile MOUD clinics; 3) reduce opioid overdoses by enhancing Naloxone distribution; and 4) enhance the Washington State prescription drug monitoring system.

The Washington State allocation is $11,790,256 per year/Two-year grant. This grant includes 18 projects – 9 prevention and 9 treatment:

- Primary and Secondary Prevention $2,355,768
- Treatment/Recovery Expansion $8,844,975
- Total amount for program development $11,200,743

Prevention

1. **Prescriber/Provider Education** ($80,000)

Host two (east side and west side of the State) 2-day symposium events for Washington State dental prescribers and oral health care providers who commonly treat youth and adults with injuries and acute pain. The events will focus on opioid prescribing practices and guidelines. Washington State Labor and Industries (L&I) is providing planning support for symposium content and speakers.

2. **UW TelePain** ($40,619)
   Provide partial funding to the University of Washington (UW) for a weekly TelePain program that provides access to a multidisciplinary panel of experts that 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.

3. **Public Education Campaign** ($868,149)
   Work with the DSHS Communications Office and additional media vendors as needed to design, test and disseminate various public education (cable, radio, newsprint, and social media) messages that promote public education with tribes to meet community needs.

4. **Safe Storage Curricula and Training** ($20,000)
   Innovative pilot project to integrate prescription drug misuse and abuse prevention education with existing state services that parents and caregivers receive. This project will engage state agencies to submit project proposals up to $5,000 to establish internal capacity to provide prescription misuse/ abuse prevention education and messaging to clients in the long-term.

5. **Prevention Workforce Enhancements** ($60,000)
   Enhance funding support to Annual Washington State Prevention Summit and Spring Youth Forum. This support will increase the availability of educational opportunities for youth and prevention professionals (and related fields) by providing presentations and workshops geared toward opiate misuse and abuse prevention.

6. **Community Prevention and Wellness Initiative (CPWI) Expansion** ($752,000)
   Using an evidenced based school and community process DBHR will develop CPWI in five (5) high-need communities to support local strategic planning and decision-making to focus on addressing local needs by implementation of evidence-based strategies and programs, as well as, initiating educational and informational community events to increase community awareness about prescription drug and opioid misuse and abuse.

7. **Analysis of Evidence-Based Practices** ($35,000)
   Contract with Washington State University to conduct analysis of current selection of evidence-based practice with outcomes in the most salient factors related to youth misuse and abuse of prescriptions drugs to include opiates to be used in implementation of prevention services.

8. **Community Enhancement Grants** ($300,000)
   Utilize application process to fund services to 10-15 communities in Washington State to implement evidence-based programs and drug take back and educational strategies over the course of one-year with the goal of reducing or preventing prescription medicine and opiate misuse and abuse.

9. **Naloxone Distribution** ($200,000)
WA-Opioid STR funding provides naloxone to vulnerable and underserved populations in partnership with ADAI by providing naloxone to places at both high relative risk (in terms of the local opioid overdose mortality rate) and high absolute risk (in terms of the total number of fatal overdoses and estimated heroin using population).

Treatment—$8,844,975

1. **Hub and Spoke** ($4,995,950 + $1,246,247 year 1 carryover = $ 6,242,197 total)
DBHR has expanded access for statewide access to Medications for Opioid Use Disorder (MOUD) and reduced unmet need by developing and implementing a six (6) hub and spoke 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 approved MOUDs 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.

2. **Mobile OTP Van** ($400,000)
Funding will be provided to Evergreen Treatment Services to purchase, customize, and deploy two mobile vans for Opioid treatment, one will be targeted in rural communities and the other will be used to expand services in urban areas.

3. **Low-Barrier Buprenorphine Pilot** ($130,000)
WA-Opioid STR together with ADAI will develop a low-barrier buprenorphine model to induce and stabilize highly vulnerable people with OUD on buprenorphine at the Seattle Indian Health Board. People will be provided buprenorphine quickly, typically within 1-48 hours, then will receive flexible dosing/prescribing so that they are able to stabilize over 30-60 days. They will be provided ongoing support of a nurse care manager and transitioned to maintenance at a community-based health clinic.

4. **PathFinder Peer Project** ($1,660,000)
PathFinder Peer Project will build on the already established DBHR Projects for Assistance in Transition from Homelessness (PATH) program to provide SUD peers recovery support in two environments, emergency rooms and homeless encampments. The project will link the individuals to needed MOUD services and assist in navigating systems and addressing barriers to independence and recovery.

5. **Tribal Treatment** ($240,000)
WA-Opioid STR funding will be used to add treatment training tracks to currently established tribal conferences, provide funding for tribal participants to attend the conferences. Funding will also be used to create and distribute a media campaign for tribes to build awareness related to MOUD treatment options for Native Americans.

6. **Treatment Payment Assistance** ($242,524)

Each of the 10 Regional Service Areas will receive funding to off-set the cost of providing treatment services to opioid use disorder patients who have financial barriers to treatment access. This funding is intended to offset deductible and co-pays for patients seeking treatment for OUD services but are unable to meet co-pay requirements.

7. **OUD Treatment Decision Re-entry Services & COORP** ($690,500)
   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 located 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 MOUD services in the county of their release, and expedites their enrollment in a Medicaid health plan.

8. **Bridge to Recovery (JRA)** ($201,000 - Year one was reduced by $16,750 to $167,500 due to late start of project)
   Develop an evidenced-based Juvenile Rehabilitation model that reduces substance abuse disorders, increases education and employment opportunities for youth and addresses systemic barriers that perpetuate the cycle, and implement ACRA reentry transition activities that link youth to mainstream services.

9. **Prescription Monitoring Program** ($250,000)
   WA-Opioid STR funding together with the Department of Health (DOH) will support PMP staffing in creating prescriber feedback reports to assist individual providers and provider groups in reviewing their prescribing practices. PMP data will also be provided to DBHR prevention data as an integral part of the developing data books in the development of the CPWI sites and other local substance use disorder planning efforts.

The Washington State Opioid Response Grant (SOR)

September 30, 2018 through September 29, 2020.

The Washington State allocation is $32,834,248 per year/Two-year grant. This grant includes 23 projects – 10 prevention, 10 treatment, and 4 recovery support services.

- Prevention $6,657,237
- Treatment $18,983,369
- Recovery Support Services Projects $5,473,300

Prevention

1. **Community Prevention and Wellness Initiative (CPWI) Expansion** ($3,769,618) – P1 (opioid response plan strategy 1.1)
   DBHR has identified the next highest-need and currently non-funded communities across the state to become sub-recipient CPWI sites through a competitive application process, conducted in October 2018. The

substance consumption and consequence indicators are each summarized into composite risk scores, using a process to standardize diverse indicators, including consumption, consequences associated with consumption (crime, truancy, lack of school success), and socio-economic data for each community. The new communities are scattered across the state, all of which were selected based on a demonstrated need for substance abuse prevention services combined with the readiness to implement strategies to address this need. These communities vary considerably in demographics, locations, and history, but in the selection

process they all demonstrated a high level of need, coupled with a readiness and willingness to invest in community-driven and evidence-based strategies and solutions.

In addition RDA will produce Data Books needed by the CPWI-STR Sites; Data Books will include community performance data, risk ranking, risk profiles focusing on prescription drug/opioid indicators needed for

community assessment, strategic planning community education, and monitoring of outcomes. Includes Technical Assistance to CPWI Communities, as well as contracting with Washington Technology Solutions (WaTech) $2,250 – The Athena Forum Excellence in Prevention (EIP) Improvements. The purpose of this project is to improve the functionality of the EIP web page. The Athena Forum is a professional development and training website for prevention professionals. The EIP page provides detailed information on evidence-based substance use prevention programs/strategies including those shown to be effective at reducing youth opioid and/or prescription drug misuse and/or associated risk factors.

2. **Fellowship Program** ($400,000)
   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 and build capacity within high-needs communities to implement prevention services. Interviews were conducted with potential Fellows from WSU who were all graduating this semester. Three candidates were selected to be a part of the Cohort 1 Fellows and started on January 2, 2019. 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.

3. Community Enhancement Grants ($800,000) – P2 (opioid response plan strategy 1.5)
DBHR identified the next high-need communities across the state to become sub-recipient community-based organization (CBO) grantees through a competitive application process, conducted in October 2018. The goal of the CBO grants is to provide direct prevention services to high-need communities. Several CBOs were selected and are implementing services, which may include implementing the direct service program(s) or the statewide Starts with One opioid prevention campaign. Each community is required to participate in the National Prescription Drug Take-Back Days in April and October of each year.

4. **Prescriber Education Training Courses** ($210,000) – P3 (opioid response plan strategy 1.2)
DBHR is currently planning the development of e-learning courses for WA healthcare providers on opioid prescribing practices for pain in partnership with the University of Washington, Labor and Industries, Bree Collaborative, and Department of Health. Trainings and e-courses will continue to be made available after the SOR funding period. DBHR will also focus on two (one east side and one west side of the State) symposium events for Washington State dental prescribers and oral health care providers who commonly

treat youth and adults with injuries and acute pain. The events focus on opioid prescribing practices and guidelines. Contract with Washington State University (WSU), University of Nevada, Reno (UNR), or Washington State Labor and Industries (L&I).

5. **Opioid Summit** ($200,000) – P4 (opioid response plan strategy 1.4, 2.3)
DBHR held the Region 10 Opioid Summit to provide education and open dialogue with state, tribal, behavioral health, medical providers, and community providers in an effort to reduce opioid use disorder. The Summit was held in partnership with Idaho, Alaska, and Oregon. There were specific components to include interventions such as naloxone, harm reduction, and other topics that supported the continuum of prevention, treatment, and recovery.

6. **Public Education Campaign** ($1,313,165) – P5 (opioid response plan strategy 1.4)
Enhancement and evaluation of the statewide Starts with One campaign. The contract with DBHR's media vendor, DH, has been amended to include the enhancement, implementation, and evaluation of the statewide Starts with One public education campaign to reach more high-need communities with intentional prevention messaging. DBHR held a meeting at the end of January to plan for the additional funding and activities for the Starts with One campaign. DH is submitting a proposal to HCA/DBHR this month to update the contract. Work with Desautel Hege (DH) and additional media vendors, as needed to design, test and disseminate various public education (cable, radio, newsprint, and social media) messages that promote public education with communities and tribes to meet community needs.

7. **Naloxone Distribution and Training Program** ($407,036 – P6 (opioid response plan strategy 3.1)
Contract with Department of Health to support the statewide naloxone distribution and training coordination. Naloxone distribution and overdose reversals are listed under Washington State Department of Health (DOH) below, as SABG funded the naloxone.

September 30, 2018 to September 29, 2019: $128,835
September 30, 2019 to September 29, 2020: $135,338
September 30, 2020 to September 29, 2021: $142,863

April 2019 to September 2019: 3,468 individuals trained on naloxone administration.

October 2019 to September 2020: 7,204 individuals trained on naloxone administration.

October 2020 to March 2021 (Partial Year): 3,767 individuals trained on naloxone administration.

There will be tobacco cessation activities in the Opioid Treatment Networks (OTNs) through the new State Opioid Response (SOR) Grant. We will have approximately 17 contractors, and the Department of Health will be providing technical assistance to them.

8. **UW TelePain** ($40,619)
   Provide partial funding to UW for a weekly TelePain program that provides access to a multidisciplinary panel of experts that 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.

9. **Safe Storage Curricula and Training** ($25,000)
   Innovative pilot project to integrate prescription drug misuse and abuse prevention education into existing state services that parents and caregivers receive. This project engages state agencies to submit project proposals up to $10,000 to establish internal capacity to provide prescription misuse/abuse prevention education and messaging.

10. **Prevention Workforce Enhancements** ($40,000)
    Enhance funding support to the annual Washington State Prevention Summit and Spring Youth Forum. This support will increase the availability of educational opportunities for youth and prevention professionals (and related fields) by providing presentations and workshops geared toward opioid misuse and abuse prevention. Contract with UNR for conference logistics.

Treatment

1. **Opioid Treatment Networks** ($7,650,000 + $221,000 = $7,871,000) – T1 (opioid response plan strategy 2.2)
   DBHR has contracted with 17 organizations (consisting of 8 emergency departments, 5 jails, 2 syringe exchanges, 1 shelter, and 1 fire department) to create Opioid Treatment Networks (OTNs) to provide: Medications for Opioid Use Disorder (MOUD) to individuals with opioid use disorder (OUD); funding to build OTN infrastructure; funding for staff; funding for MOUD 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 in order 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. The majority of OTNs have executed their contracts, and many have already inducted individuals onto MOUD. $221,000 moved from DOH tobacco cessation to pay contractors directly for tobacco cessation deliverables.

2. **OTN TA/Training** ($550,000) – 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. ADAI will also provide support to DSHS Juvenile Rehabilitation for the development of an OTN ($50,000).

3. **MAT Treatment Assistance** ($500,000) – T3 (opioid response plan strategy 2.2)
   DBHR is entering into contracts with Behavioral Health Organizations, Managed Care Organizations, Administrative Service Organizations, and providers in all 10 regions of the state to increase access to MOUD services for underinsured and uninsured, clients. This is a required component of the SOR FOA and enhances funding already provided by the STR Grant.

4. **OTN Tobacco Cessation** ($700,000-$221,000 to T1 = $479,000) – T4
   DBHR is entering into a contract with the Department of Health (DOH) to provide services for OTNs and OTN clients, including WA Tobacco Quitline services, such as phone counseling and nicotine replacement therapy, Tobacco Treatment Specialist (TTS) training for OTN staff and training for providers on cross-addiction, and Quitline referrals processes. $221,000 transferred to OTNs directly for tobacco cessation deliverable.

5. **Grant to Tribal Communities** ($464,000) – T5 (opioid response plan strategy 1.1)
   Tribal prevention and treatment grants to 13 tribes ($346,000) 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).

6. **OUD Treatment Decision Re-entry Services & COORP** ($2,671,852) – 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 located 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 MOUD services in the county of their release, and expedites their enrollment in a Medicaid health plan.

7. **WSU Contracted Services** ($521,557) – T7
   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 Tribal Media Liaison to manage Tribal media environment.

8. **Hub & Spoke** ($5,595,950)

DBHR utilizing STR funding expanded access statewide access to MOUD 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 MOUDs 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 MOUD services statewide.

Additionally, each hub will also be provided a Data Collection Coordinator ($100,000 each hub) to ensure SOR GPRA is completed. Current funding is based on STR grant, $789,825 per Hub & Spoke network. Total per network with additional position $889,825 x 6= $5,338,950. Technical assistance provided by the University of Washington, ADAI (Alcohol & Drug Abuse Institute) $257,000. Total Cost: $5,595,950

9. **Low-Barrier Buprenorphine Pilot** ($130,000)
ADAI together with the Seattle Indian Health Board, provide a low-barrier MOUD clinic to stabilize highly vulnerable people with Opioid Use Disorder (OUD) on buprenorphine in a community-based setting. People are provided services quickly, typically within 24-hours, and receive flexible dosing/prescribing so that they are able to stabilize over 30-60 days. They are provided ongoing nurse care manager support and transitioned to maintenance at a community-based health clinic. The goal of the project is to provide low barrier access to highly vulnerable, often homeless urban American Indian, Alaskan Native individuals.

10. **Tribal Treatment** ($200,010)
Tribal Treatment provides funding to add MOUD treatment training tracks to currently established tribal conferences and provide funding for tribal participants to attend the conferences ($60,000). Create and distribute media campaigns for tribes to build awareness related to MOUD treatment options for Native Americans ($140,010). The goal of the project is to work collaboratively with recognized tribal governments to engage in MOUD services.

Recovery

1. **OUD and MAT Training to Community Recovery Support Services** ($15,000) – R1 (opioid response plan strategy 2.2.5)
TA/training will be provided to staff at: Catholic Community Services in Burlington, Everett Recovery Café, Seattle Recovery Café, Peer Seattle/Seattle Area Support Groups, Tacoma Recovery Café, and Comprehensive Healthcare in Walla Walla, Okanogan Behavioral Healthcare, Spokane Recovery Café and Vancouver Recovery Café. Recovery Support Staff will be provided scholarships and training costs to attend the Region X Opioid Symposium in August 2019.

2. **Client-directed Recovery Support Services** ($2,750,000) – R2 (opioid response plan strategy 2.2.5)
Contracted direct recovery support services to Catholic Community Services in Burlington, Everett Recovery Café, Seattle Recovery Café, Peer Seattle/Seattle Area Support Groups, Tacoma Recovery Café,

Comprehensive Healthcare in Walla Walla, Okanogan Behavioral Healthcare, Spokane Recovery Café and Vancouver Recovery Café.

3. **Peer Recovery Support** ($1,085,000) – R3 (opioid response plan strategy 2.2.5)
   Contracted peer recovery staff for: Catholic Community Services in Burlington, Everett Recovery Café, Seattle Recovery Café, Peer Seattle/Seattle Area Support Groups, Tacoma Recovery Café, Comprehensive

   Healthcare in Walla Walla, Okanogan Behavioral Healthcare, Spokane Recovery Café and Vancouver Recovery Café.

4. **PathFinder Peer Project** ($1,623,300)
   Description: PathFinder Peer Project builds on the already established DBHR Projects for Assistance in Transition from Homelessness (PATH) program to provide substance use disorder (SUD) peer recovery support in two environments, emergency rooms and homeless encampments. The project links individuals to needed MOUD services and assist in navigating systems and addressing barriers to independence and recovery. The goal of the project is to provide SUD peers in environments with high populations of individuals with OUD.

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

Naloxone distribution to 5 High Need Areas (HNA) across Washington State. Each HNA includes multiple counties.

Year 1: (January 2017 to August 2017)
Individuals Trained: 426
Naloxone Kits Distributed: 2,728 (includes refills)
Overdose Reversals: 389

Year 2: (September 2017 to August 2018)
Individuals Trained: 1,118
Naloxone Kits Distributed: 9,227 (includes refills)
Overdose Reversals: 1,538

Year 3: (September 2018 to August 2019)
Individuals Trained: 5,356
Naloxone Kits Distributed: 10,678 (includes refills)
Overdose Reversals: 2,572

Year 4: (September 2019 to August 2020)
Individuals Trained: 3,437
Naloxone Kits Distributed: 9,497 (includes refills)
Overdose Reversals: 2,083

Year 5: (Partial Year: September 2020 to April 2021)
Individuals Trained: 1,634
Naloxone Kits Distributed: 7,151 (includes refills)
Overdose Reversals: 1,608

This grant continues through August 31, 2021.

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

Funding from the SABG is allocated for naloxone distribution. This is part of the sustainability plan to continue naloxone distribution statewide after the WA-PDO grant ends 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 and 459 reported overdose reversals.

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

October 2020 to March 2021 (Partial Year): 6,940 kits distributed and 1,395 reported overdose reversals.

Implementation of Secure Withdrawal Management and Stabilization Facilities

The 2016 Legislative Session, House Bill 1713 directed DBHR to create Secure Withdrawal Management and Stabilization Facilities and made changes to multiple aspects of the behavioral health system. Effective April 1, 2018, the bill amends

RCW 71.05 and 71.34 to align the substance use involuntary Treatment process with the existing mental health ITA process.

DBHR created a 16-hour training program for all DMHPs on substance use disorders processes and petitioning for initial detention of SUD into the mental health detention process. All DMHPs have taken the training provided by HCA.

On April 1, 2018, two adult facilities opened and are currently providing withdrawal management services, American Behavioral Health Services (ABHS) Chehalis (21) beds and American Behavioral Health Services (ABHS) Spokane (24)

beds. ABHS has added voluntary services, and some mental health services as of January 2020, however they still prioritize ITA. Historically both sites are full but manage to see clients in a timely manner.
These facilities are licensed as a Secure Withdrawal Management and Stabilization facility (SWMS), certified by Department of Health (DOH) to provide services in accordance with American Society of Addiction Medicine (ASAM) 3.7 Withdrawal Management services. These facilities provide up to 17 days of withdrawal management and stabilizing care to individuals who present a likelihood of serious harm to themselves or others, other's property, or are gravely disabled due to a substance use disorders (SUD). Individuals in need of (SUD) treatment longer than seventeen days may receive outpatient or residential treatment voluntarily, or on a less restrictive alternative court orders.

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. The hope was that Department of Health would pick up the task of a co-occurring WAC for services as well as for credentialing of staff.

To date the co-occurring WAC has not been completed and work is not yet in process to develop a co-occurring credential.

Planning Steps

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

Narrative Question:

This step should identify the unmet service needs and critical gaps in the state's current M/SUD system of care 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 M/SUD system of care.
States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, SUD prevention, and SUD treatment goals at the state level.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Washington State Health Care Authority

Washington

UNIFORM APPLICATION
FY 2022/2023 – 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

Division of Behavioral Health and Recovery
FFY22-FFY23 Block Grant Application
September 1, 2021

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 M/SUD system 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 M/SUD system. Especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps.

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

In addition to in-state data, SAMHSA has identified several other data sets that are available to states through various federal agencies: CMS, the Agency for Healthcare Research and Quality (AHRQ), and others.

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

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 American Indian (AI)/Alaska Native (AN) population, who have the option of receiving mental health and substance use disorder treatment through the

Medicaid managed care system or through a fee-for-service delivery system. The state will continue to

maintain the TARGET System for data collection from the fee-for-service system until a replacement is found.

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 State Prevention Enhancement Policy Consortium's State Substance Abuse Prevention and Mental Health Promotion Strategic Plan. Using a data-based approach, the Washington State Prevention Enhancement Policy Consortium (SPE) developed an update to the state's Substance Use Disorder Prevention and Mental Health Promotion Strategic Plan, completed in Fall 2019. The Consortium is comprised of representatives from 26 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 and 2017, and both past plans and the current plan are posted at www.TheAthenaForum.org/spe. Over the next year, the

Consortium will undergo an in-depth five-year strategic planning process, undergoing a needs and resources assessment, a deep dive into the community and state level workforce and training needs and identify programmatic areas that need a greater focus in the next five years.

Strategy to Identify Unmet Needs and Gaps

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. The last HYS was conducted in the fall of 2018 and provided data for DBHR's needs assessment, including broadening surveillance capacity for LGBTQ communities, teen anxiety, and substance use issues related to vapor products. After a postponement of the 2020 HYS due the COVID-19 pandemic, the next HYS will be administered in fall 2021, for the first time as an electronic survey.

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 marijuana 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 marijuana 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.

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.

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 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.

An important aspect of DBHR's surveillance work is providing increasingly sophisticated access to data for our program managers, BHOs, and other providers. DBHR has created the System for Communicating Outcomes, Performance & Evaluation (SCOPE) http://www.scopewa.net, a web-based mental health and substance abuse reporting system. It consists of two broad functions: 1) standard reports, which typically address issues of general interest to constituents in pre-formatted output and 2) an ad hoc query function that allows users to perform analyses and data summaries using a drop-down menu interface. Improvements made to the SCOPE system design in 2017 will integrate data from the new Behavioral Health Data System. This redesign will result in a user interface that better corresponds with administrative changes, as well as extensive modification to existing reports and creation of new reports to improve information provided to SCOPE users. The new system will be available for the BHOs, program managers, legislative staff and other stakeholders.

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 continue to be a priority for substance use and mental health disorder services. This goal is focused on addressing these rates by offering a direct allocation to Tribes through our government-to-government Indian Nation Agreements.

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 penetration continue to be a focus of substance use disorder treatment services as the state moves to 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.
DBHR 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 6: Increase capacity for early identification and intervention for individuals experiencing First Episode Psychosis.
DBHR 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.
DBHR 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.

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

Planning Tables

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: SAP, SAT

Population(s): PWWDC, PP, PWID, TB, Other (American Indian/Alaska Native; Tribal and Urban Communities)

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.

Strategies to attain the goal:

• 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: 4,499

First-year target/outcome measurement: SUD Treatment - Individuals Served: 3,400

Second-year target/outcome measurement: SUD Treatment - Individuals Served: 3,400

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 by Tribes, total number of AI/AN clients served between July 1, 2019 and June 30, 2020.

Data issues/caveats that affect outcome measures:

• Indian Health Care Providers have to enter 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 as promised in 2016. 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 is also transitioning vendors in Fall 2021 and Tribes will need to learn a new system, this may increase data reporting challenges in some areas. HCA is working to ensure all Tribes are supported and engaged in this process to minimize the impact.

Priority #: 2

Priority Area: Reduce Underage and Young Adult Substance Use/Misuse

Priority Type: SAP

Population(s): PP, Other (Adolescents w/SA and/or MH, Rural, Asian, Native Hawaiian/Other Pacific Islanders, Underserved Racial and Ethnic Minorities, American Indian/Alaska Native; Tribal and Urban Communities)

Goal of the priority area:

Decrease the use and misuse of alcohol, marijuana, tobacco, opioids or other prescription drugs, and the use of any other drugs in the last 30 days.

Strategies to attain the goal:

• 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).
• Provide statewide Workforce Development Training to build capacity for service delivery.
• Develop best practices strategies to target underserved populations such as Tribal and urban Indian communities, Black, Indigenous, and People of Color.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Reduce substance use/misuse

Baseline Measurement: Average of 15,590 unduplicated participants served by direct services provided between SFY 2014-2019 (July 1, 2013 – June 30, 2019)

First-year target/outcome measurement: Increase or maintain 15,590 unduplicated participants in direct services prevention programs.

Second-year target/outcome measurement: Increase or maintain 15,590 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 is also transitioning vendors in Fall 2021 and all providers will need to learn a new system, this may increase data reporting challenges in some areas. 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: SAT

Population(s): PWWDC, PWID, Other (Adolescents w/SA and/or MH, LGBTQ, Rural, Criminal/Juvenile Justice, Children/Youth at Risk for BH Disorder, Homeless, Asian, Native Hawaiian/Other Pacific Islanders, Underserved Racial and Ethnic Minorities, American Indian/Alaska Native; Tribal and Urban Communities)

Goal of the priority area:

Increase the treatment initiation and engagement rates among the number of youths accessing substance use disorder outpatient services.

Strategies to attain the goal:

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.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase youth outpatient SUD treatment services

Baseline Measurement: SFY20 (July 1, 2019 – June 30, 2020): 1,695 youth received SUD outpatient treatment services

First-year target/outcome measurement: Increase the number of youths receiving SUD outpatient treatment services in SFY22 to 3,584

Second-year target/outcome measurement: Increase the number of youths receiving SUD outpatient treatment services in SFY23 to 3,684

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 2016 data is an unduplicated count of youth (persons under 18 years of age) served in publicly funded SUD outpatient treatment between January 1, 2017, and December 31, 2018.

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: SAT

Population(s): PWWDC, PWID, TB, Other (Adolescents w/SA and/or MH, Students in College, LGBTQ, Children/Youth at Risk for BH Disorder, Homeless, Asian, Native Hawaiian/Other Pacific Islanders, Underserved Racial and Ethnic Minorities, American Indian/Alaska Native; Tribal and Urban Communities)

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

Strategies to attain the goal:

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

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: SUD peer support program

Baseline Measurement: From July 1, 2019 – June 30, 2020 total number of SUD trained peers was 802

First-year target/outcome measurement: Peer support program in SFY22 that would train 280 peers

Second-year target/outcome measurement: Peer support program in SFY23 that would train 350 peers

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: MHS

Population(s): SED

Goal of the priority area:

The primary goal is to maintain community based behavioral health services to youth who are diagnosed with SED.

Strategies to attain the goal:

• Require 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: SFY20: 68,113 youth with SED received services

First-year target/outcome measurement: Maintain the number of youths with SED receiving outpatient services to at least 54,293 in SFY22 (we anticipate a decrease in numbers, bringing us closer to our normal baseline as Covid decreases)

Second-year target/outcome measurement: Maintain the number of youths with SED receiving outpatient services to at least 54,293 in SFY23 SFY22 (we anticipate a decrease in numbers, bringing us closer to our normal baseline as Covid decreases)

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 2018 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, 2017 through June 30, 2018.

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.

Priority Type: MHS

Population(s): SMI, SED

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).

Strategies to attain the goal:

• 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: SFY20: 11 First Episode Psychosis (FEP) Programs, serving a total of 325 youth

First-year target/outcome measurement: FY22 (July 1, 2021 – June 30, 2022) Increase the number of coordinated specialty care sites from 11 to 12 serving an additional 25 youth statewide (total of 350 youth served).

Second-year target/outcome measurement: FY23 (July 1, 2022 – June 30, 2023) Maintain the 12 coordinated specialty care sites, serving an additional 75 youth statewide (total of 425 youth served).

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: MHS

Population(s): SMI, Other (LGBTQ, Homeless, Asian, Native Hawaiian/Other Pacific Islanders, Underserved Racial and Ethnic Minorities, American Indian/Alaska Natives; Tribal and Urban Communities)

Goal of the priority area:

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

Strategies to attain the goal:

• 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: SFY20: 192,662 adults with Serious Mental Illness (SMI) received mental health outpatient services

First-year target/outcome measurement: Maintain a minimum of 104,128 adults with Serious Mental Illness (SMI) receiving mental health outpatient services in SFY22 (we anticipate a decrease in numbers, bringing us closer to our normal baseline as Covid decreases)

Second-year target/outcome measurement: Maintain a minimum of 104,128 adults with Serious Mental Illness (SMI) receiving mental health outpatient services in SFY22 (we anticipate a decrease in numbers, bringing us closer to our normal baseline as Covid decreases)

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 2020 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, 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 #: 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: SAT, MHS

Population(s): SMI, SED, PWWDC, PWID, TB, Other (Homeless, Asian, Native Hawaiian/Other Pacific Islanders, Underserved Racial and Ethnic Minorities, American Indian/Alaska Native; Tribal and Urban Communities)

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.

Strategies to attain the goal:

- 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: FY2020 – 4,437 enrollments in supported employment

First-year target/outcome measurement: Increase average number of people receiving supported employment services per month (over 12-month period) by 4% in FY22 (total 4,614 enrollments)

Second-year target/outcome measurement: Increase number of people receiving supported employment services per month (over 12-month period) by 4% in FY23 (total 4,798 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: FY2020 – 5,199 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 FY22 (total 5,406 enrollments)

Second-year target/outcome measurement: Increase average number of people receiving supportive housing services per month (over 12-month period) by 4% in FY23 (total 5,622 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

Priority Type: SAT

Population(s): PWWDC, PWID, TB, Other (LGBTQ, Criminal/Juvenile Justice, Asian, Native Hawaiian/Other Pacific Islanders, Underserved Racial and Ethnic Minorities, American Indian/Alaska Native; Tribal and Urban Indian Communities)

Goal of the priority area:

Increase the number of adults receiving outpatient SUD treatment including adults who are using opioids and other prescription drugs.

Strategies to attain the goal:

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

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase outpatient SUD for adults in need of SUD treatment

Baseline Measurement: SFY20: 40,293

First-year target/outcome measurement: Increase the number of adults in SFY22 to 47,875

Second-year target/outcome measurement: Increase the number of adults in SFY23 to 48,888.

Data Source:

The number of adults receiving SUD outpatient services 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 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 Women

Priority Type: SAT

Population(s): PP

Goal of the priority area:

Increase the number of Pregnant and Parenting Women (PPW) clients receiving case management services

Strategies to attain the goal:

• 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: As of June 2021, the total contracted number of Pregnant and Parenting Women (PPW) clients receiving PCAP case management services is 1409.

First-year target/outcome measurement: Increase the number of Pregnant and Parenting Women (PPW) clients receiving PCAP case management services (an estimated increase of anywhere from 82-92 client slots, depending on the per client rate determined per county)

Second-year target/outcome measurement: 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:

- Impacts of the current/ongoing COVID pandemic.
- If funding is reduced for any reason, the number of sites/clients served may decrease.

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Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [SA]

States must project how the SSA will use available funds to provide authorized services for the planning period for state fiscal years FFY 2022/2023.
ONLY include funds expended by the executive branch agency administering the SABG.

Planning Period Start Date: Planning Period End Date:

Activity (See instructions for using Row 1.)	Source of Funds									
	A. Substance Abuse Block Grant	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. COVID-19 Relief Funds (MHBG)[a]	I. COVID-19 Relief Funds (SABG)[a]	J. ARP Funds (SABG)[b]
1. Substance Abuse Prevention[c] and Treatment	$52,892,785.00		$694,886,450.00	$118,726,355.00	$106,356,050.00	$0.00	$0.00		$22,691,951.00	$8,595,097.00
a. Pregnant Women and Women with Dependent Children[c]	$3,778,146.00		$14,748,050.00		$3,075,000.00				$0.00	$0.00
b. All Other	$49,114,639.00		$680,138,400.00	$118,726,355.00	$103,281,050.00				$22,691,951.00	$8,595,097.00
2. Primary Prevention[d]	$18,890,281.00		$0.00	$0.00	$13,161,000.00	$0.00	$0.00		$6,047,208.00	$1,531,829.00
a. Substance Abuse Primary Prevention	$18,890,281.00				$13,161,000.00				$6,047,208.00	$1,531,829.00
b. Mental Health Primary Prevention										
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)										
4. Tuberculosis Services									$0.00	$0.00
5. Early Intervention Services for HIV									$0.00	$0.00
6. State Hospital										
7. Other 24-Hour Care										
8. Ambulatory/Community Non-24 Hour Care										
9. Administration (excluding program/provider level) MHBG and SABG must be reported separately	$3,778,056.00				$7,701,850.00	$1,342,750.00			$1,493,902.00	$325,921.00
10. Crisis Services (5 percent set-aside)										
11. Total	**$75,561,122.00**	**$0.00**	**$694,886,450.00**	**$118,726,355.00**	**$127,218,900.00**	**$1,342,750.00**	**$0.00**	**$0.00**	**$30,233,061.00**	**$10,452,847.00**

[a] The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is July 1, 2021 – June 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between July 1, 2021 – March 14, 2023 should be entered in Column I.

[b] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is July 1, 2021 – June 30, 2023. For purposes of this table, all planned ARP supplemental expenditures between September 1, 2021 and June 30, 2023 should be entered in Column J.

[c] Prevention other than primary prevention

[d] The 20 percent set aside funds in the SABG must be used for activities designed to prevent substance misuse.

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Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [MH]

States must project how the SMHA will use available funds to provide authorized services for the planning period for state fiscal years 2022/2023.
Include public mental health services provided by mental health providers or funded by the state mental health agency by source of funding.

Planning Period Start Date: 7/1/2021 Planning Period End Date: 6/30/2023

Activity (See instructions for using Row 1.)	Source of Funds									
	A. Substance Abuse Block Grant	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. COVID-19 Relief Funds (MHBG)[a]	I. COVID-19 Relief Funds (SABG)	J. ARP Funds (MHBG)[b]
1. Substance Abuse Prevention and Treatment										
a. Pregnant Women and Women with Dependent Children										
b. All Other										
2. Primary Prevention										
a. Substance Abuse Primary Prevention										
b. Mental Health Primary Prevention[e]					$594,500.00			$0.00		$0.00
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)[d]		$3,129,228.00						$1,969,390.00		$849,107.00
4. Tuberculosis Services										
5. Early Intervention Services for HIV										
6. State Hospital								$0.00		$0.00
7. Other 24-Hour Care								$0.00		$0.00
8. Ambulatory/Community Non-24 Hour Care		$27,085,802.00	$1,910,621,999.00	$15,334,000.00	$283,962,712.00			$12,470,561.00		$6,424,420.00
9. Administration (excluding program/provider level)[f] MHBG and SABG must be reported separately		$1,564,614.00	$31,513,625.00	$1,010,650.00	$2,972,500.00			$820,366.00		$353,795.00
10. Crisis Services (5 percent set-aside)[g]		$1,672,612.00						$1,149,024.00		$707,590.00
11. Total	**$0.00**	**$33,452,256.00**	**$1,942,135,624.00**	**$16,344,650.00**	**$287,529,712.00**	**$0.00**	**$0.00**	**$16,409,341.00**	**$0.00**	**$8,334,912.00**

[a] The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" SABG and MHBG. Per the instructions, the standard SABG expenditures are for the state planned expenditure period of July 1, 2021 – June 30, 2023, for most states.

[b] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025,** which is different from expenditure period for the "standard" MHBG. Per the instructions, the standard MHBG expenditures captured in Columns A-G are for the state planned expenditure period of July 1, 2021 - June 30, 2022, for most states

[d] Column 3B should include Early Serious Mental Illness programs funded through MHBG set aside.

[e] While a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

[f] Per statute, administrative expenditures cannot exceed 5% of the fiscal year award.

[g] Row 10 should include Crisis Services programs funded through different funding sources, including the MHBG set aside. States may expend more than 5 percent of their MHBG allocation.

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Footnotes:

Planning Tables

Table 3 SABG Persons in need/receipt of SUD treatment

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
1. Pregnant Women	0	44
2. Women with Dependent Children	0	281
3. Individuals with a co-occurring M/SUD	0	0
4. Persons who inject drugs	0	113
5. Persons experiencing homelessness	0	602

Please provide an explanation for any data cells for which the state does not have a data source.

The TEDS Admissions did not include data on co-occurring mental and substance use disorders.

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Footnotes:

Planning Tables

Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

Expenditure Category	FFY 2022 SA Block Grant Award	COVID-19 Award[1]	ARP Award[2]
1 . Substance Use Disorder Prevention and Treatment[3]	$26,446,474.00	$22,691,951.00	$8,809,196.00
2 . Primary Substance Use Disorder Prevention	$9,445,073.00	$6,047,208.00	$1,623,054.00
3 . Early Intervention Services for HIV[4]		$0.00	$0.00
4 . Tuberculosis Services		$0.00	$0.00
5 . Administration (SSA Level Only)	$1,889,014.00	$1,493,902.00	$345,331.00
6. Total	**$37,780,561.00**	**$30,233,061.00**	**$10,777,581.00**

[1]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 –September 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between October 1, 2021 – March 14, 2023 should be entered in this column.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 – September 30, 2023. For purposes of this table, all planned ARP supplemental expenditures between October 1, 2021 and September 30, 2023 should be entered in this column.

[3]Prevention other than Primary Prevention

[4]For the purpose of determining which states and jurisdictions are considered "designated states" as described in section 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 45 CFR § 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant (SABG); Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by the Centers for Disease Control and Prevention (CDC,), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention. The most recent HIV Surveillance Report published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective SABG allotments to establish one or more projects to provide early intervention services regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a "designated state" in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state's AIDS case rate does not meet the AIDS case rate threshold for the fiscal year involved for which a state is applying for SABG funds. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance would will be allowed to obligate and expend SABG funds for EIS/HIV if they chose to do so.

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Footnotes:

Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

A		B		
Strategy	IOM Target	FFY 2022		
		SA Block Grant Award	COVID-19[1]	ARP[2]
1. Information Dissemination	Universal	$2,262,925	$784,635	$0
	Selective	$0	$0	$0
	Indicated	$0	$0	$0
	Unspecified	$0	$0	$0
	Total	**$2,262,925**	**$784,635**	**$0**
2. Education	Universal	$1,036,114	$468,227	$0
	Selective	$34,503	$9,668	$0
	Indicated	$281	$79	$0
	Unspecified	$0	$0	$0
	Total	**$1,070,898**	**$477,974**	**$0**
3. Alternatives	Universal	$91,420	$25,616	$0
	Selective	$0	$0	$0
	Indicated	$0	$0	$0
	Unspecified	$0	$0	$0
	Total	**$91,420**	**$25,616**	**$0**
4. Problem Identification and Referral	Universal	$43,879	$12,295	$0
	Selective	$0	$175,610	$0
	Indicated	$1,433,413	$755,685	$0
	Unspecified	$0	$0	$0
	Total	**$1,477,292**	**$943,590**	**$0**
	Universal	$5,406,340	$1,585,106	$0

5. Community-Based Process				
	Selective	$0	$0	$0
	Indicated	$0	$0	$0
	Unspecified	$0	$0	$0
	Total	**$5,406,340**	**$1,585,106**	**$0**
6. Environmental	Universal	$56,106	$15,721	$0
	Selective	$0	$0	$0
	Indicated	$0	$0	$0
	Unspecified	$0	$0	$0
	Total	**$56,106**	**$15,721**	**$0**
7. Section 1926 Tobacco	Universal	$0	$0	$0
	Selective	$0	$0	$0
	Indicated	$0	$0	$0
	Unspecified	$0	$0	$0
	Total	**$0**	**$0**	**$0**
8. Other	Universal	$651,108	$182,444	$0
	Selective	$0	$0	$0
	Indicated	$0	$0	$0
	Unspecified	$64,457	$27,960	$47,258
	Total	**$715,565**	**$210,404**	**$47,258**
Total Prevention Expenditures		**$11,080,546**	**$4,043,046**	**$47,258**
Total SABG Award[3]		**$37,780,561**	**$30,233,061**	**$10,777,581**
Planned Primary Prevention Percentage		**40.16 %**	**50.18 %**	**140.76 %**

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 - September 30, 2023, for most states.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 - September 30, 2023.

[3]Total SABG Award is populated from Table 4 - SABG Planned Expenditures

Footnotes:

Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

Activity	FFY 2022 SA Block Grant Award	COVID-19 Award[1]	ARP Award[2]
Universal Direct	$7,706,730	$1,891,784	$0
Universal Indirect	$1,841,162	$1,182,260	$0
Selective	$34,503	$185,278	$0
Indicated	$1,433,694	$755,764	$0
Column Total	**$11,016,089**	**$4,015,086**	**$0**
Total SABG Award[3]	**$37,780,561**	**$30,233,061**	**$10,777,581**
Planned Primary Prevention Percentage	**29.16 %**	**13.28 %**	**0.00 %**

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 - September 30, 2023, for most states.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 - September 30, 2023.

[3]Total SABG Award is populated from Table 4 - SABG Planned Expenditures

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Footnotes:

For COVID-19 Award- Other: Unspecified included $27,959,94

Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

States should identify the categories of substances the state BG plans to target with primary prevention set-aside dollars from the FFY 2022 and FFY 2023 SABG awards.

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

	SABG Award	COVID-19 Award[1]	ARP Award[2]
Targeted Substances			
Alcohol	☑	☑	☑
Tobacco	☑	☑	☑
Marijuana	☑	☑	☑
Prescription Drugs	☑	☑	☑
Cocaine	☑	☑	☑
Heroin	☑	☑	☑
Inhalants	☑	☑	☑
Methamphetamine	☑	☑	☑
Bath salts, Spice, K2)	☑	☑	☑
Targeted Populations			
Students in College	☑	☑	☑
Military Families	☑	☑	☑
LGBTQ	☑	☑	☑
American Indians/Alaska Natives	☑	☑	☑
African American	☑	☑	☑
Hispanic	☑	☑	☑
Homeless	☑	☑	☑
Native Hawaiian/Other Pacific Islanders	☑	☑	☑
Asian	☑	☑	☑
Rural	☑	☑	☑

Underserved Racial and Ethnic Minorities			

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 – September 30, 2023, for most states.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 – September 30, 2023.

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Footnotes:

Planning Tables

Table 6 Non-Direct Services/System Development [SA]

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

Activity	FFY 2022				
	A. SABG Treatment	B. SABG Prevention	C. SABG Integrated[1]	D. COVID-19[2]	E. ARP[3]
1. Information Systems	$368,277.00	$92,397,502.00			$0.00
2. Infrastructure Support	$434,150.00	$0.00			$0.00
3. Partnerships, community outreach, and needs assessment	$0.00	$0.00		$48,001.16	$0.00
4. Planning Council Activities (MHBG required, SABG optional)	$0.00	$0.00			$0.00
5. Quality Assurance and Improvement	$338,391.00	$0.00			$0.00
6. Research and Evaluation	$168,833.00	$0.00		$55,609.74	$0.00
7. Training and Education	$208,711.00	$26,328,853.00			$0.00
8. Total	**$1,518,362.00**	**$118,726,355.00**	**$0.00**	**$103,610.90**	**$0.00**

[1]Integrated refers to non-direct service/system development expenditures that support both treatment and prevention systems of care.

[2]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 –September 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between October 1, 2021 – March 14, 2023 should be entered in Column D.

[3]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 – September 30, 2023. For purposes of this table, all planned ARP supplemental expenditures between October 1, 2021 and September 30, 2023 should be entered in Column E.

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Footnotes:

Planning Tables

Table 6 Non-Direct-Services/System Development [MH]

MHBG Planning Period Start Date: 07/01/2021 MHBG Planning Period End Date: 06/30/2023

Activity	FFY 2022 Block Grant	FFY 2022[1] COVID Funds	FFY 2022[2] ARP Funds	FFY 2023 Block Grant	FFY 2023[1] COVID Funds	FFY 2023[2] ARP Funds
1. Information Systems	$496,484.00	$0.00	$0.00	$496,484.00	$0.00	$0.00
2. Infrastructure Support		$158,049.00	$0.00		$72,439.00	$649,889.00
3. Partnerships, community outreach, and needs assessment		$222,439.00	$0.00		$101,951.00	$61,803.00
4. Planning Council Activities (MHBG required, SABG optional)	$51,250.00	$0.00	$0.00	$51,250.00	$0.00	$0.00
5. Quality Assurance and Improvement	$1,345,794.00	$0.00	$0.00	$1,345,794.00	$0.00	$0.00
6. Research and Evaluation		$0.00	$0.00		$0.00	$0.00
7. Training and Education	$2,584,767.00	$923,707.00	$0.00	$2,584,767.00	$423,366.00	$352,352.00
8. Total	**$4,478,295.00**	**$1,304,195.00**	**$0.00**	**$4,478,295.00**	**$597,756.00**	**$1,064,044.00**

[1] The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15,2021 - March 14, 2023**, which is different from the expenditure period for the "standard" SABG and MHBG. Per the instructions, the standard MHBG expenditures are for the state planned expenditure period of July 1, 2021 - June 30, 2023, for most states.

[2] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" MHBG. Per the instructions, the standard MHBG expenditures are for the state planned expenditure period of July 1, 2021 - June 30, 2023, for most states.

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Footnotes:

Environmental Factors and Plan

1. The Health Care System, Parity and Integration - Question 1 and 2 are Required

Narrative Question

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.[22] Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but "[h]ealth system factors" such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.[23] It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.[24]

Currently, 50 states have organizationally consolidated their mental and substance use disorder authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.[25] SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.[26] For instance, some organizations have established medical-legal partnerships to assist persons with mental and substance use disorders in meeting their housing, employment, and education needs.[27]
Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and M/SUD with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.[28]

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.[29] The state should illustrate movement towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders. The plan should describe attention to management, funding, payment strategies that foster co-occurring capability for services to individuals and families with co-occurring mental and substance use disorders. Strategies supported by SAMHSA to foster integration of physical and M/SUD include: developing models for inclusion of M/SUD treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between M/SUD providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as Federally Qualified Health Centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including EHRs and telehealth are examples of important strategies to promote integrated care.[30] Use of EHRs - in full compliance with applicable legal requirements - may allow providers to share information, coordinate care, and improve billing practices. Telehealth is another important tool that may allow M/SUD prevention, treatment, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time, and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes[31] and ACOs[32] may be important strategies used by SMHAs and SSAs to foster integrated care. Training and assisting M/SUD providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes.
SMHAs and SSAs also may work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations.[33] Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.[34]

One key population of concern is persons who are dually eligible for Medicare and Medicaid.[35] Roughly, 30 percent of persons who are dually eligible have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.[36] SMHAs and SSAs also should collaborate with state Medicaid agencies and state insurance commissioners to develop policies to assist those individuals who experience health insurance coverage eligibility changes due to shifts in income and employment.[37] Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with M/SUD conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider.[38] SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of M/SUD conditions and work with

partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.
SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.[39] Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists, and others will need to understand integrated care models, concepts, and practices.

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to M/SUD services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. The SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. The SSAs and SMHAs should collaborate with their states' Medicaid authority in ensuring parity within Medicaid programs.
SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues.
Another key part of integration will be defining performance and outcome measures. The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, which includes information and resources to help promote health, good outcomes, and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.[40]
SAMHSA recognizes that certain jurisdictions receiving block grant funds - including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Medicaid provisions or are ineligible to participate in certain programs.[41] However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment, and recovery support for persons with, or at risk of, mental and substance use disorders.

[22] BG Druss et al. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Med Care. 2011 Jun; 49(6):599-604; Bradley Mathers, Mortality among people who inject drugs: a systematic review and meta-analysis, Bulletin of the World Health Organization, 2013; 91:102-123 **http://www.who.int/bulletin/volumes/91/2/12-108282.pdf**; MD Hert et al., Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care, World Psychiatry. Feb 2011; 10(1): 52-77

[23] Research Review of Health Promotion Programs for People with SMI, 2012, **http://www.integration.samhsa.gov/health-wellness/wellnesswhitepaper**; About SAMHSA's Wellness Efforts, **https://www.samhsa.gov/wellness-initiative**; JW Newcomer and CH Hennekens, Severe Mental Illness and Risk of Cardiovascular Disease, JAMA; 2007; 298: 1794-1796; Million Hearts, **https://www.samhsa.gov/million-hearts-initiative**; Schizophrenia as a health disparity, **http://www.nimh.nih.gov/about/director/2013/schizophrenia-as-a-health-disparity.shtml**

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

[25] Social Determinants of Health, Healthy People 2020, **http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39**; **https://www.cdc.gov/nchhstp/socialdeterminants/index.html**

[26] **https://www.samhsa.gov/behavioral-health-equity/quality-practice-workforce-development**

[27] **http://medical-legalpartnership.org/mlp-response/how-civil-legal-aid-helps-health-care-address-sdoh/**

[28] Integrating Mental Health and Pediatric Primary Care, A Family Guide, 2011. **https://www.integration.samhsa.gov/integrated-care-models/FG-Integrating,_12.22.pdf**; Integration of Mental Health, Addictions and Primary Care, Policy Brief, 2011, **https://www.ahrq.gov/downloads/pub/evidence/pdf/mhsapc/mhsapc.pdf**; Abrams, Michael T. (2012, August 30). Coordination of care for persons with substance use disorders under the Affordable Care Act: Opportunities and Challenges. Baltimore, MD: The Hilltop Institute, UMBC. **http://www.hilltopinstitute.org/publications/CoordinationOfCareForPersonsWithSUDSUnderTheACA-August2012.pdf**; Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes, American Hospital Association, Jan. 2012, **http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf**; American Psychiatric Association, **http://www.psych.org/practice/professional-interests/integrated-care**; Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series (2006), Institute of Medicine, National Affordable Care Academy of Sciences, **http://books.nap.edu/openbook.php?record_id=11470&page=210**; State Substance Abuse Agency and Substance Abuse Program Efforts Towards Healthcare Integration: An Environmental Scan, National Association of State Alcohol/Drug Abuse Directors, 2011, **http://nasadad.org/nasadad-reports**

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

[30] Health Information Technology (HIT), http://www.integration.samhsa.gov/operations-administration/hit; Characteristics of State Mental Health Agency Data Systems, Telebehavioral Health and Technical Assistance Series, **https://www.integration.samhsa.gov/operations-administration/telebehavioral-health**; State Medicaid Best Practice, Telemental and Behavioral Health, August 2013, American Telemedicine Association, **http://www.americantelemed.org/home**; National Telehealth Policy Resource Center, **https://www.cchpca.org/topic/overview/**;

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

[32] New financing models, **https://www.integration.samhsa.gov/financing**

[33] Waivers, **http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html**; Coverage and Service Design Opportunities for Individuals with Mental Illness and Substance Use Disorders, CMS Informational Bulletin, Dec. 2012, **http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-12-03-12.pdf**

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

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

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

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

[39] Hoge, M.A., Stuart, G.W., Morris, J., Flaherty, M.T., Paris, M. & Goplerud E. Mental health and addiction workforce development: Federal leadership is needed to address the growing crisis. Health Affairs, 2013; 32 (11): 2005-2012; SAMHSA Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues, January 2013, **https://www.cibhs.org/sites/main/files/file-attachments/samhsa_bhwork_0.pdf**; Creating jobs by addressing primary care workforce needs, **https://obamawhitehouse.archives.gov/the-press-office/2012/04/11/fact-sheet-creating-health-care-jobs-addressing-primary-care-workforce-n**

[40] About the National Quality Strategy, **http://www.ahrq.gov/workingforquality/about.htm**;

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

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

1. Describe how the state integrates mental health and primary health care, including services for individuals with co-occurring mental and substance use disorders, in primary care settings or arrangements to provide primary and specialty care services in community -based mental and substance use disorders settings.

In 2020 Washington’s Medicaid system fully transitioned from two distinct managed care systems to a ‘whole person’ system of care whereby the full continuum of physical and behavioral health care is 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. As of January 1, 2020, all of the nine regional service areas (RSAs) implemented fully integrated managed care (FIMC).

2. Describe how the state provides services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, and payment strategies that foster co-occurring capability.

In April 2016, our state’s integration efforts were further bolstered by Washington State Department of Social and Health Services (DSHS) integrating the management of the mental health and substance use disorder systems of care. Washington moved from a mental health system managed by Regional Service Networks (RSNs) and a substance use disorder treatment system managed by the counties, to both being managed by managed care entities: Behavioral Health Organizations (BHOs) or Managed Care Organizations (MCOs). The most effective treatment for individuals with dual diagnoses integrates mental health and substance use interventions. This management model provides a better opportunity for supporting individuals with dual diagnoses by working to increase the number of facilities that can provide dual treatment, increasing the number of dually certified providers, and supporting improved care coordination and communication between disciplines. This integrated model will continue as the state moves toward fully integrated care as described in question 1.

The National Survey on Drug Use and Health (NSDUH) 2010/2011 data reports that 75 percent of individuals in Washington State with mental health or substance use disorder conditions also have chronic medical conditions. Fully integrated managed care implemented across the state will position Washington State to provide whole-person care along a continuum of need. As a result of integrating the behavioral health delivery system, the state fully integrated the managed care payments that were provided for mental health services and the fee-for-service payments provided for substance use disorder services into a behavioral health managed care rate. This provides the flexibility for the BHOs and MCOs to provide services across the continuum of substance use and mental health disorders and removes a funding silo. The state continues to review and update state rules and laws, contract language, state plan authority and funding strategies to support more models of co-occurring services. Recent changes include integrating previously separate SUD and MH licensing rules into one behavioral health rule set. This work is being done in partnership with the BHOs, MCOs, providers and other stakeholders with the goal to provide as much clarity and flexibility within our current laws, funding, and state plan to support co-occurring delivery models.

3. **a)** Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through Qualified Health Plans? ○ Yes ○ No

   b) and Medicaid? ○ Yes ○ No

4. Who is responsible for monitoring access to M/SUD services provided by the QHP?

5. Is the SSA/SMHA involved in any coordinated care initiatives in the state? ○ Yes ○ No

6. Do the M/SUD providers screen and refer for:

   a) Prevention and wellness education ○ Yes ○ No

   b) Health risks such as

   - **ii)** heart disease ○ Yes ○ No
   - **iii)** hypertension ○ Yes ○ No
   - **iv)** high cholesterol ○ Yes ○ No
   - **v)** diabetes ○ Yes ○ No

   c) Recovery supports ○ Yes ○ No

7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care? ○ Yes ○ No

8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services? ○ Yes ○ No

9. What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions?

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

    Please indicate areas of technical assistance needed related to this section

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Footnotes:

Environmental Factors and Plan

2. Health Disparities - Requested

Narrative Question

In accordance with the **HHS Action Plan to Reduce Racial and Ethnic Health Disparities**[42], **Healthy People, 2020**[43], **National Stakeholder Strategy for Achieving Health Equity**[44], 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/gender minorities, orientation and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, 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 recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS)[45].

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

The HHS Secretary's top priority in the Action Plan is to "assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."[46]

Collecting appropriate data is 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[47]. 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[48]. 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, LGBTQ 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. 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.

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

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

[44] **https://www.minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS_07_Section3.pdf**

[45] **http://www.ThinkCulturalHealth.hhs.gov**

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

[47] https://aspe.hhs.gov/basic-report/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-and-disability-status

[48] 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 ○ No
b) Ethnicity	○ Yes ○ No
c) Gender	○ Yes ○ No
d) Sexual orientation	○ Yes ○ No
e) Gender identity	○ Yes ○ No
f) Age	○ Yes ○ No

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 ○ No
3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers? ○ Yes ○ No
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? ○ Yes ○ No
5. If yes, does this plan include the Culturally and Linguistically Appropriate Services(CLAS) Standards? ○ Yes ○ No
6. Does the state have a budget item allocated to identifying and remediating disparities in M/SUD care? ○ Yes ○ No
7. Does the state have any activities related to this section that you would like to highlight?

   Please indicate areas of technical assistance needed related to this section

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Footnotes:

Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

While there are different ways to define value-based purchasing, its purpose is to identify services, payment arrangements, incentives, and players that can be included in directed strategies using purchasing practices that are aimed at improving the value of health care services. In short, health care value is a function of both cost and quality:

Health Care Value = Quality ÷ Cost, (**V = Q ÷ C**)

SAMHSA anticipates that the movement toward value based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of M/SUD systems and services.

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

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. SAMHSA's Evidence Based Practices Resource Center assesses the research evaluating an intervention's impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. SAMHSA's Evidence-Based Practices Resource Center provides the information & tools needed to incorporate evidence-based practices into communities or clinical settings.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with SED. The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General,[49] The New Freedom Commission on Mental Health,[50] the IOM,[51] NQF,and the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC).[52]. The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."[53] SAMHSA and other federal partners, the HHS' Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the M/SUD field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocol Series **(TIPS)**[54] are best practice guidelines for the SUD treatment. SAMHSA draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation **(KIT)**[55] was developed to help move the latest information available on effective M/SUD practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement M/SUD practices that work. KIT covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

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

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

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

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

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

[53] **http://psychiatryonline.org/**

[54] **http://store.samhsa.gov**

[55] **https://store.samhsa.gov/sites/default/files/d7/priv/ebp-kit-how-to-use-the-ebp-kit-10112019_0.pdf**

Please respond to the following items:

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions? ○ Yes ○ No

2. Which value based purchasing strategies do you use in your state (check all that apply):

- **a)** ☐ Leadership support, including investment of human and financial resources.
- **b)** ☐ Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
- **c)** ☐ Use of financial and non-financial incentives for providers or consumers.
- **d)** ☐ Provider involvement in planning value-based purchasing.
- **e)** ☐ Use of accurate and reliable measures of quality in payment arrangements.
- **f)** ☐ Quality measures focused on consumer outcomes rather than care processes.
- **g)** ☐ Involvement in CMS or commercial insurance value based purchasing programs (health homes, accountable care organization, all payer/global payments, pay for performance (P4P)).
- **h)** ☐ The state has an evaluation plan to assess the impact of its purchasing decisions.

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

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

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Footnotes:

Environmental Factors and Plan

4. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) - 10 percent set aside - Required MHBG

Narrative Question

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.

Please respond to the following items:

1. Does the state have policies for addressing early serious mental illness (ESMI)? ◉ Yes ○ No

2. Has the state implemented any evidence-based practices (EBPs) for those with ESMI? ◉ Yes ○ No

If yes, please list the EBPs and provide a description of the programs that the state currently funds to implement evidence-based practices for those with ESMI.

The Mental Health Block Grant (MHBG) 10 percent set aside currently supports eleven Coordinated Specialty Care (CSC) teams. This includes the initial New Journeys Demonstration Project in Central Washington in Yakima, which began in 2015, and subsequent launch of four additional sites including Thurston-Mason and King Counties in 2016, Grays Harbor County in 2017 and Clark County in 2018. In 2019 the statewide expansion included the addition of four additional sites including Greater Columbia in Pasco, North Central in Wenatchee, Pierce County in Tacoma, and King County in Seattle. Despite the pandemic, 2020 included expansion of two more CSC teams, one in Spokane and the other in Bremerton bringing the total number of teams to eleven covering nine regions of Washington.

All sites receive training, technical assistance, and consultation from a team of local and national experts led by Dr. Maria Monroe-DeVita from the University of Washington (UW) Department of Psychiatry and Behavioral Sciences. Dr. Monroe-DeVita is the project director and oversees all aspects of implementation, including program start up, training, ongoing

consultation, and coordination and planning between the New Journeys CSC teams and DBHR. Dr. Monroe-DeVita is joined by her training team at UW, in consultation with national experts from the NAVIGATE program to ensure proper training and fidelity for New Journeys.

University of Washington Implementation Team
Maria Monroe-DeVita, PhD –Trainer for Program Director & Family Education Specialists
Sarah Kopelovich, PhD Trainer in IRT and other psychotherapeutic interventions
Carolyn Brenner, MD –Trainer for Psychiatric Care Providers
Jonathan Beard, LICSW and Dawn Miller, (DBHR) – Trainers for Supported Employment & Education (SEE) Specialists
Lorrin Gehring (Community Voices Are Born - CVAB) – Trainer for Peer Specialists
Ryan Melton, PhD (EASA Center of Excellence) – SCID & Differential Diagnosis

3. How does the state promote the use of evidence-based practices for individuals with ESMI and provide comprehensive individualized treatment or integrated mental and physical health services?

At the recommendation of the Children and Youth Behavioral Health Work Group (CYBHWG) Legislation 2SSB 5903 (2019) was passed and directed the Health Care Authority to implement New Journeys CSC early identification and intervention program statewide by 2023. The Legislation also called for creation of a Statewide Implementation Plan to inform the expansion by identifying the level of unmet need, developing a team-based payment structure, analyzing existing health benefits (Medicaid and commercial), and determining funding resources needed to ensure that individuals across the state of Washington will be able to access these critical services regardless of their geographic area of residence or insurance enrollment status.
The Statewide Implementation Plan was submitted to the Legislature 1/28/2021 and HCA contracted with Mercer Government Human Service Consulting (Mercer) to develop a comprehensive Medicaid team-based rate for New Journeys CSC.

4. Does the state coordinate across public and private sector entities to coordinate treatment and recovery supports for those with ESMI? ◉ Yes ○ No

5. Does the state collect data specifically related to ESMI? ◉ Yes ○ No

6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI? ◉ Yes ○ No

7. Please provide an updated description of the state's chosen EBPs for the 10 percent set-aside for ESMI.

Teams, utilizing New Journeys Coordinated Specialty Care Navigate model, are comprised of four to six clinicians with the appropriate expertise. Key roles, in addition to outreach and engagement, include team leadership, case management, supported employment and education, psychotherapy and skills training, CBTp. family education and support, pharmacotherapy, medication management, co-occurring substance use disorder counseling, peer support and primary care coordination. Supervision and consultation is provided within the context of the recommendations for each role, as directed by the UW Implementation Team consultants.

8. Please describe the planned activities for FFY 2022 and FFY 2023 for your state's ESMI programs including psychosis?

The planned activities for FFY 2022 and FFY 2023 are:

• Continue expansion of New Journeys CSC as prescribed in SSSB 5903, "adequate number of teams based on incidence and population." The goal is the implementation and training of at least six additional New Journeys CSC teams.
• Continue development of the value-based team payment model established for Medicaid and complete the rate certification process.
• Continue advocacy to establish parity with commercial insurance.
• Address racial disparities through a statistical analysis of race/ethnicity differences in FEP incidence rates in Washington State.
• Develop rural and AIAN New Journeys/CSC model, evaluate it, and broadly disseminate the results to inform future program development.
• Develop a dissemination strategy to increase reach to racially and ethnically diverse communities and community awareness about first episode psychosis and New Journeys.
• Create a youth advisory council to support individuals enrolled or previous enrolled in New Journeys.
• Address substance use and the implementation of an evidence-based substance use intervention within New Journeys.
• Support the UW Pilot of the Family Bridger Program: training and support of families and caregivers of youth and young adults experiencing a first episode of psychosis.
• Continued statewide development of the UW tele health resource for centralized specialized screening and assessment of psychosis. The Central Assessment of Psychosis Service (CAPS) will provide a direct tele-evaluation of the young person using a HIPAA-secure telehealth platform.

The objectives of the New Journeys Network are to:

• Reduce the duration of untreated psychosis through early and appropriate detection and response, thereby potentially reducing severity of the illness.

• Minimize the disruption in the lives of adolescents and young adults who experience psychosis so they can reintegrate and maintain educational, vocational, social, and other roles.

• Minimize the societal impact of psychosis including reducing demand in other areas of the mental health and the health and social service systems and reducing disruption in the lives of families.

• Use the gathered data for quality improvement in existing programs and to improve the implementation of future sites.

•Statewide availability of CSC for FEP and support current service providers.

9. Please explain the state's provision for collecting and reporting data, demonstrating the impact of the 10 percent set-aside for ESMI.

There are two prongs of data collection. The first is with the Washington State Department of Social and Health Services (DSHS), Research and Data Analysis (RDA) Division, which collects and summarizes data on DSHS clients who have experienced psychotic episodes. They provide descriptive data on demographics, behavioral health characteristics, family history (when available), services that have been required from state systems, arrests and involvement with juvenile justice system, and trajectories from the first encounter with psychosis. RDA is using this data to operationalize a definition of First Episode Psychosis through administrative data.

Washington State University (WSU) collects program specific data pertaining to outreach activities, engagement and retention of youth and families in the New Journeys Program, clinical outcomes of participants (including program costs and savings), and individual and family experience. WSU provides both qualitative and quantitative data analysis to inform program development and implementation.

Washington State University Evaluation Team
• Oladunni Oluwoye, PhD, CHES – Assistant Professor – Lead Evaluator
• Michael McDonell, PhD – Professor – Lead Evaluator
• Bryony Stokes, BA – Program Coordinator
• Elisabeth Frazier, MSc – Program Coordinator

The state has contracted with the University of Washington (UW) to provide technical assistance and ongoing training and oversight in order to increase the providers' capacity to deliver services. Technical assistance includes team start-up and organizational capacity, program direction/team leadership, differential diagnosis, family education and support, peer-based services and support, and evidence-based treatments such as Individual Resiliency Training (IRT), Cognitive Behavioral Therapy (CBTp) for Psychosis, and skills training. They provide direct organizational, clinical, and case-based consultation. The state and UW have also facilitated collaboration between new sites and veteran sites in order improve the implementation and program development process.

WSU will collaborate with RDA to develop a comparison study to determine the effectiveness of early psychosis intervention using the NAVIGATE Model in Washington State. RDA's mission is to provide policy makers and program managers with relevant data, analyses, and information to support innovations that improve the effectiveness of services for clients and to provide DSHS program staff and contracted service providers with access to data-driven decision support applications to improve decisions about client care. The partnership between the New Journeys Network, WSU, and RDA will provide the data required to conduct a meaningful analysis to measure the impact of this initiative.

10. Please list the diagnostic categories identified for your state's ESMI programs.

• Age Range: 15-25 with exceptions made up to 40 years old, based on clinical judgment and treatment match for the New Journey's Model

• Diagnoses: Schizophrenia, Schizoaffective Disorder, Schizophreniform Disorder, Brief Psychotic Disorder, delusional disorder, or other specified schizophrenia spectrum and other psychotic disorder.

• Duration of Illness/Symptoms: >1 week and < 2 years AND/OR < 12 months of lifetime treatment with antipsychotic medications. Only one episode of psychosis (i.e., individuals with a psychotic episode followed by full system remission and relapse to another psychotic episode are excluded)

• Exclusion Criteria: Intellectual disability (IQ > 70) and/or Autism; Psychotic symptoms secondary to 1) a pervasive developmental disorder. 2) a medical or neurologic condition. 3) prescription drug or substance use. Two or more discrete psychotic episodes.

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

None at this time.

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5. Person Centered Planning (PCP) - Required MHBG

Narrative Question

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.

1. Does your state have policies related to person centered planning? (●) Yes ( ) No

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

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 Navigate 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, Navigate, 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 at least one goal identified by the individual or their parent or legal representative and 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.

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

None at this time.

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6. Program Integrity - Required

Narrative Question

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

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for 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 SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SABG 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 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 SABG 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 SABG funds are allocated to support evidence-based, culturally competent programs, substance use disorder 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 SABG. 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 items:

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 ○ No

2. Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards? ◉ Yes ○ No

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.

Please indicate areas of technical assistance needed related to this section

None at this time.

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7. Tribes - Requested

Narrative Question

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the **2009 Memorandum on Tribal Consultation**[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 has the state conducted with federally recognized tribes?

The State of Washington follows the Revised Code of Washington RCW 43.376 pertaining to the Stat'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.

- HCA-Tribal Government-to-Government Protocol and Plan for Coordination of Services, Sept. 2020
- Tribal Listening Session on SUD 1115 Demonstration Waiver Mid-Point Assessment, Jan. 2020
- Amendments to the Section 1115 Medicaid Waiver and the Section 1915b Behavioral Health Waiver, Feb. 2020
- State's contracts with the Medicaid Managed Care Organizations (MCOs) and the Behavioral Health Administrative Services Organizations (BH-ASOs), Feb. 2020
- Tribal General Welfare Exclusion Act with the Cowlitz Tribe of Indians,
- Tribal-MCO Transition, Medicaid Quality Strategy, Compliance Monitoring, Mar. 2020
- Electronic Consent Management Implementation Information Gathering, June 12, 2020
- Medicaid Transformation Consultation, Dec 2020
- Medicaid Managed Care Contracts, Dec 2020
- Indian Nation Agreement, Feb 2021
- Residential SUD Treatment Enhancement State Plan Amendment, Mar 2021
- Tribal Designated Crisis Responder WAC, May 2021
- Non-Emergency Medical Transportation Contract, Jun. 2021

- Primary Care Case Management Contract, Jun. 2021
- SAMHSA FY22 Block Grant Application, Jul./Aug. 2021

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.
- Tribe 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.
- Tribes have identified a concern on how the General Welfare Exclusion impact affect Tribal elders in being able to access Medicaid resources for health services.
- In 2020 the Tribes raised significant concerns related to working and receiving payments for services from Managed Care Entities. Other concerns included the inappropriate credentialing processes of MCOs on sovereign nations that may be greater than the State and federal oversight.
- During consultation regarding contracting with Tribes and data systems, there remains a concern raised regarding administrative burden placed on Tribes related to Tribal
- 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 has elevated the development of crisis planning protocols to a G2G level in partnership with local crisis entities and has taken the responsibility to coordinate this work with Tribes and local crisis partners.
- HCA has launched the development of an Indian Behavioral Health Hub in the spring of 2020. This hub is mean to support Tribes, non-Tribal Indian Health Care Providers, and non-Tribal crisis partnering in navigation of the BH and crisis systems on behalf of AI/AN individuals in need. The hub has information and expertise on non-Tribal BH and crisis services across the state as well as knowledge and expertise in Tribal BH resources and how to bring these two complex systems together to support individuals in accessing the culturally and medically necessary BH services.
- 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.

HCA is seeking technical assistance related to federal grant pass down subrecipient federal language that may not apply to Tribes or that may conflict with a federal rule for Tribal governments. Our team is seeking guidance and TA on how HHS navigates some of the federal rules that may not apply to Tribes, but States are asked to pass these down to their contractors.
This request is important because we have received feedback from Indian Nations that some of these passes down regulations conflict with federal rules specifically for Tribal governments or Tribes have their own rules that they follow rather than these rules.
We would like to know if SAMHSA has any experience in navigating these topics with Indian Nations through other direct grants such as the TOR, and if SAMSHA is able to provide us with TA on moving these forwards and the best way to go about collaborating with Tribes to ensure that we are not passing down language that conflicts with federal rules that Tribes follow. The items that have been stated to be problematic include drug-free workplace requirements, accessibility provisions (Civil Rights Law), and Tobacco.

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8. Primary Prevention - Required SABG

Narrative Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified 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 disorder 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 SABG 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 Process*** 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 items

Assessment

1. Does your state have an active State Epidemiological and Outcomes Workgroup(SEOW)? ◉ Yes ○ No

2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply) ◉ Yes ○ No

- **a)** ☑ Data on consequences of substance-using behaviors
- **b)** ☑ Substance-using behaviors
- **c)** ☑ Intervening variables (including risk and protective factors)
- **d)** ☑ Other (please list)

Local contributing factors.

3. Does your state collect needs assesment data that include analysis of primary prevention needs for the following population groups? (check all that apply)

- ☑ Children (under age 12)
- ☑ Youth (ages 12-17)
- ☑ Young adults/college age (ages 18-26)
- ☑ Adults (ages 27-54)
- ☐ Older adults (age 55 and above)
- ☑ Cultural/ethnic minorities
- ☑ Sexual/gender minorities
- ☑ Rural communities
- ☐ Others (please list)

4. Does your state use data from the following sources in its Primary prevention needs assesment? (check all that apply)

☑ Archival indicators (Please list)

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, and Monitoring the Future. Washington additionally uses two state-developed survey instrument: the Healthy Youth Survey and the Young Adult Health Survey.
The following Archival indicators are used as well:
a. WA Department of Health and DSHS Research and Data Analysis:
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;
vi. Opioid related deaths – All Opioids; Prescription; Heroin.
b. Uniform Crime Reporting:
i. Arrests - Alcohol Violation;
ii. Arrests – Alcohol Related;
iii. Arrests – Drug Violation;
iv. Arrests – Drug Related.
c. Office of Superintendent of Public Instruction:
i. HS 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 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
i. Washington State Liquor and Cannabis Control Board:
i. Count of State Liquor Licenses;
ii. Count of State Marijuana Store Licenses and Processor Licenses

☑ National survey on Drug Use and Health (NSDUH)

☑ Behavioral Risk Factor Surveillance System (BRFSS)

☑ Youth Risk Behavioral Surveillance System (YRBS)

☑ Monitoring the Future

☐ Communities that Care

☑ State - developed survey instrument

☐ Others (please list)

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

5. Does your state use needs assesement data to make decisions about the allocation SABG primary ◉ Yes ○ No

prevention funds?

If yes, (please explain)

Yes. Washington State uses data prepared by the state SEOW to support its substance use prevention needs assessment and to support decision-making regarding the allocation to high need communities of SABG primary prevention funds related to underage alcohol, tobacco, prescription drugs/opioids, and marijuana use, misuse, and abuse.

If no, (please explain) how SABG funds are allocated:

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified 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 disorder 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 SABG 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;
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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.

Capacity Building

1. Does your state have a statewide licensing or certification program for the substance use disorder prevention workforce? ◉ Yes ○ No

If yes, please describe

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 use disorder prevention workforce? ◉ Yes ○ No

If yes, please describe mechanism used

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:
o New Coordinator Training – overview of Community Prevention and Wellness Initiative and SPF Models.
o Community Data Book Training – how to use data to conduct a community needs assessment.
o Goals, Objectives, Strategy Selection Training – how to prioritize local conditions and intervening variables to select program objectives and outcomes.
o Evaluation Training – how to conduct an evaluation of programs and use results
o 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.
o 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.
o In calendar year 2020, training topics included: Prevention practices to reduce disparities and increase positive outcomes; Mentoring relationships and substance use prevention; Brining HOPE into practice; and Fostering resiliency, where presenters provided information to increase attendees capacity to understand trauma and lead with hope for positive change.
• 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.
o Webinar training topics in calendar year 2021 included: Student Assistance Prevention & Intervention Services Program; Prevention of Homeless Youth and Family Reconciliation and how CPWI can get involved; Department of Health's Youth Cannabis and Tobacco Prevention Program

• DBHR Technical Assistance Training and On-going Support:
o 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);
o 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 ○ No

If yes, please describe mechanism used

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.

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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.

Planning

1. Does your state have a strategic plan that addresses substance use disorder prevention that was developed within the last five years? ◉ Yes ○ No

If yes, please attach the plan in BGAS by going to the **Attachments Page** and upload the plan

Yes. The current State of Washington Substance Abuse and Mental Health Promotion Five-Year Strategic Plan was developed in 2012. It was updated in 2015 and 2017, and both past plans and the current plan are posted at www.TheAthenaForum.org/spe. The plan was completed in Fall 2019.

2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SABG? (N/A - no prevention strategic plan) ◉ Yes ○ No ○ N/A

3. Does your state's prevention strategic plan include the following components? (check all that apply):

a) ☑ Based on needs assessment datasets the priorities that guide the allocation of SABG primary prevention funds

b) ☑ Timelines

c) ☑ Roles and responsibilities

d) ☑ Process indicators

e) ☑ Outcome indicators

f) ☑ Cultural competence component

g) ☑ Sustainability component

h) ☑ Other (please list):

1. Resource assessment.
2. Prevention research theories.
3. Workforce development.
4. Prevention/SUD policy tracking/review.

i) ☐ Not applicable/no prevention strategic plan

4. Does your state have an Advisory Council that provides input into decisions about the use of SABG primary prevention funds? ◉ Yes ○ No

5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SABG primary prevention funds? ◉ Yes ○ No

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 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 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.

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Implementation

1. States distribute SABG primary prevention funds in a variety of different ways. Please check all that apply to your state:

- **a)** ☑ SSA staff directly implements primary prevention programs and strategies.
- **b)** ☑ The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).
- **c)** ☐ The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.
- **d)** ☐ The SSA funds regional entities that provide training and technical assistance.
- **e)** ☑ The SSA funds regional entities to provide prevention services.
- **f)** ☑ The SSA funds county, city, or tribal governments to provide prevention services.
- **g)** ☑ The SSA funds community coalitions to provide prevention services.
- **h)** ☑ The SSA funds individual programs that are not part of a larger community effort.
- **i)** ☑ The SSA directly funds other state agency prevention programs.
- **j)** ☐ Other (please describe)

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. Please see the introduction above for definitions of the six strategies:

a) Information Dissemination:

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.

b) Education:

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.

c) Alternatives:

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.

d) Problem Identification and Referral:

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.

e) Community-Based Processes:

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.

f) Environmental:

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.

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 ○ No

If yes, please describe

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.

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Evaluation

1. Does your state have an evaluation plan for substance use disorder prevention that was developed within the last five years? (●) Yes ( ) No

If yes, please attach the plan in BGAS by going to the **Attachments Page** and upload the plan

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 over 80 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 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? (check all that apply):

a) [x] Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks

b) [x] Includes evaluation information from sub-recipients

c) [x] Includes SAMHSA National Outcome Measurement (NOMs) requirements

d) [x] Establishes a process for providing timely evaluation information to stakeholders

e) [x] Formalizes processes for incorporating evaluation findings into resource allocation and decision-making

f) [x] Other (please list:)

1. Reports to sub-recipients
2. Evaluation of trainings offered by DBHR.

g) [ ] Not applicable/no prevention evaluation plan

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

a) ☑ Numbers served

b) ☑ Implementation fidelity

c) ☐ Participant satisfaction

d) ☑ Number of evidence based programs/practices/policies implemented

e) ☑ Attendance

f) ☑ Demographic information

g) ☑ Other (please describe):

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 Radio Outlets that Distributed Media Disseminated
10. Number Weeks Radio Media Ran
11. Number of People Reached by TV
12. Number of TV Outlets that Distributed Media Disseminated
13. Number of Weeks TV Media Ran
14. Number of People Reach By Newspaper/Press Release/Magazine Disseminated
15. Number of Newspaper/Magazine/Press Release Run
16. Number of Newspapers/Magazines That Ran
17. Number of People Reach By Poster/Stickers Disseminated
18. Number of People Reach By Billboard Disseminated
19. Number Weeks Billboards Ran
20. Number of People Reached By Events
21. Number of Events
22. Number Users of Webpage
23. Number New Visitors of Webpage
24. Number Returning Visitors of Webpage
25. Number Unique Page Views of Webpage
26. Average Session Duration (Hours) of Webpage
27. Average Session Duration (Minutes) of Webpage
28. Average Time On Site (Hours) of Webpage
29. Average Time On Site (Minutes) of Webpage
30. Enter Number Followers on Social Media
31. Number of Social Media Posts (FB, Twitter, Etc) on Social Media
32. Number New Page Likes/Followers on Social Media
33. Number Clicked Post/Tweet (From All Posts/Tweets That Month) on Social Media
34. Number Who Reacted To Post To All Posts/Tweets (Liked/Shared/Commented) on Social Media
35. Social Media Display Ads
36. Enter Number of Website Clicks on Social Media Display Ads
37. Target population
38. Target age group

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

a) ☐ 30-day use of alcohol, tobacco, prescription drugs, etc

b) ☐ Heavy use

☐ Binge use

☐ Perception of harm

c) ☐ Disapproval of use

d) ☑ Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)

e) ☑ Other (please describe):

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;
vi. Opioid related deaths – All Opioids; Prescription; Heroin.
b. Uniform Crime Reporting:
i. Arrests - Alcohol Violation;
ii. Arrests – Alcohol Related;
iii. Arrests – Drug Violation;
iv. Arrests – Drug Related.
c. Office of Superintendent of Public Instruction:
i. HS 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 Misuse/Abuse (10th Grade);
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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. 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
iii. Monthly revenue/sales of products

Footnotes:

Community Prevention and Wellness Initiative (CPWI) Evaluation Plan

2021-2023 Biennium

Prepared by:
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August 2021

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Executive Summary

The purpose of this document is to provide a detailed evaluation plan for the Community Prevention and Wellness Initiative (CPWI) evaluation activities to be conducted in the 2021-2023 Biennium (July 1, 2021 – June 30, 2023).[1] CPWI is a strategic, data-informed, community coalition model aimed at preventing youth substance use by targeting prevention efforts in the highest need communities throughout the state. We plan to use the RE-AIM framework, one of the most popular evaluation tools used in public health, to conduct CPWI evaluation activities. The RE-AIM framework emphasizes the evaluation of 5 dimensions of an initiative:

- **R**each: proportion and representativeness of participants
- **E**ffectiveness: program outcomes
- **A**doption: proportion and representativeness of settings implementing the program
- **I**mplementation: quality of delivery, fidelity, adaptation, cost
- **M**aintenance: sustainability of program outcomes, and sustainability of programs

We will use the RE-AIM framework to organize all the individual topical reports that we provide separately over the course of the contract period to DBHR. Those include 5 types of reports during the 2021-2023 Biennium[2]:

1. Impact Over Time Analysis Substance Use Outcomes Report
2. Impact Over Time School Outcomes Report
3. Capacity-Building Evaluation Report
4. Substance Abuse and Mental Health Services Administration Partnerships for Success (SAMHSA-PFS) 2018 Evaluation Report
5. RE-AIM Evaluation Report

See below for a visual depiction of how each report maps onto the RE-AIM framework. The details of each type of report, including its purpose, questions, data sources, plan of analysis, timeline, and deliverables are included in the subsequent sections. This document also includes a separate section detailing the plan for dissemination of evaluation findings.

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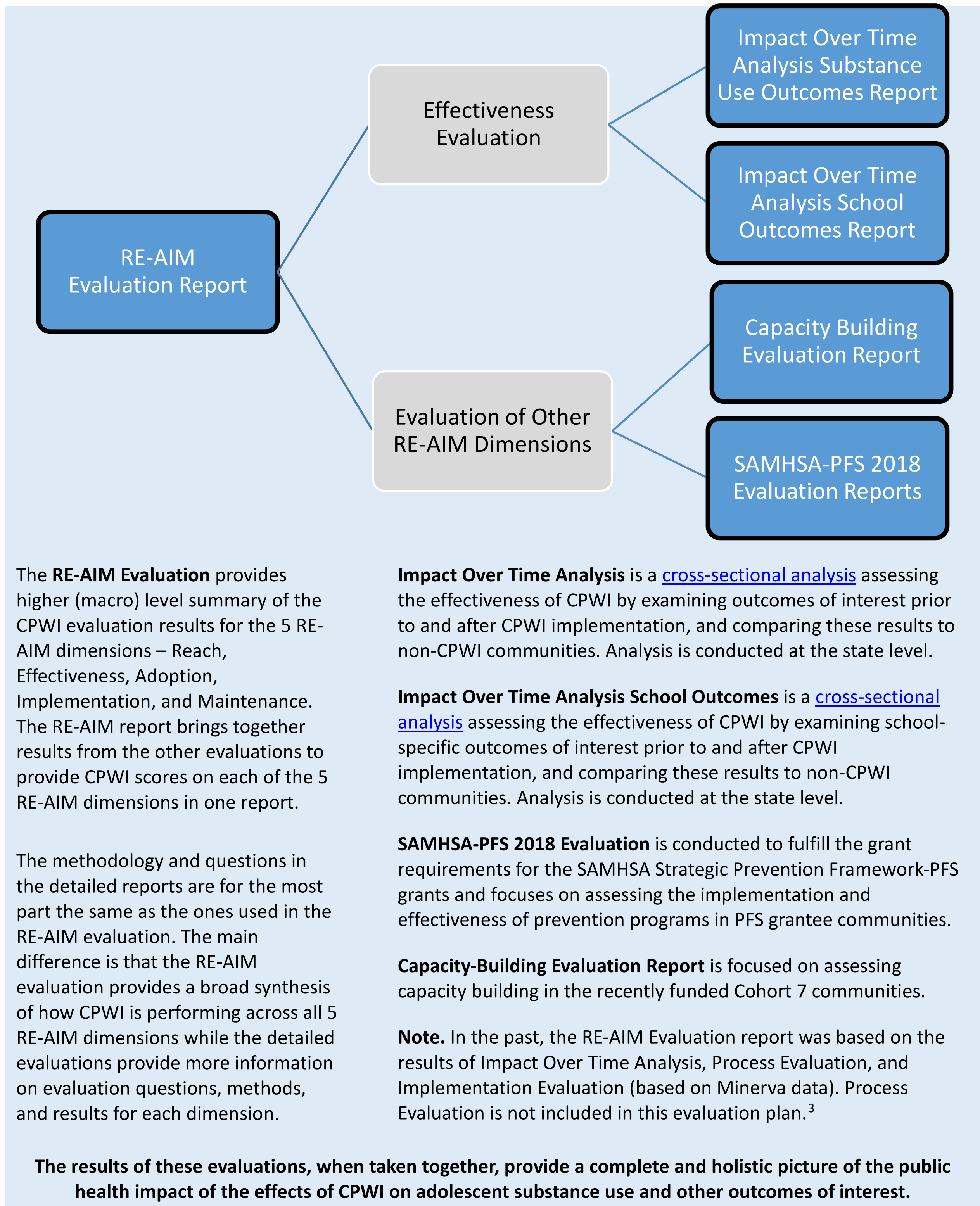
[1] We recommend using the Navigation Pane option (which can be found on the "View" tab above) to see an overview of the different sections and to move through the evaluation plan with ease. We have included a glossary of terms in Appendix A. Statistical terms are hyperlinked to this glossary.

[2] We will consider the potential effects of COVID-19 pandemic when interpreting the results and note them in the report. For outcome evaluation reports, we will also consider the potential implications of HYS 2021 breaking the cohort trend of data.

CPWI Evaluation Plan for the 2021-2023 Biennium



The **RE-AIM Evaluation** provides higher (macro) level summary of the CPWI evaluation results for the 5 RE-AIM dimensions – Reach, Effectiveness, Adoption, Implementation, and Maintenance. The RE-AIM report brings together results from the other evaluations to provide CPWI scores on each of the 5 RE-AIM dimensions in one report.

The methodology and questions in the detailed reports are for the most part the same as the ones used in the RE-AIM evaluation. The main difference is that the RE-AIM evaluation provides a broad synthesis of how CPWI is performing across all 5 RE-AIM dimensions while the detailed evaluations provide more information on evaluation questions, methods, and results for each dimension.

Impact Over Time Analysis is a cross-sectional analysis assessing the effectiveness of CPWI by examining outcomes of interest prior to and after CPWI implementation, and comparing these results to non-CPWI communities. Analysis is conducted at the state level.

Impact Over Time Analysis School Outcomes is a cross-sectional analysis assessing the effectiveness of CPWI by examining school-specific outcomes of interest prior to and after CPWI implementation, and comparing these results to non-CPWI communities. Analysis is conducted at the state level.

SAMHSA-PFS 2018 Evaluation is conducted to fulfill the grant requirements for the SAMHSA Strategic Prevention Framework-PFS grants and focuses on assessing the implementation and effectiveness of prevention programs in PFS grantee communities.

Capacity-Building Evaluation Report is focused on assessing capacity building in the recently funded Cohort 7 communities.

Note. In the past, the RE-AIM Evaluation report was based on the results of Impact Over Time Analysis, Process Evaluation, and Implementation Evaluation (based on Minerva data). Process Evaluation is not included in this evaluation plan.[3]

The results of these evaluations, when taken together, provide a complete and holistic picture of the public health impact of the effects of CPWI on adolescent substance use and other outcomes of interest.

[3] This evaluation plan is based on the reports and deliverables included in the draft contract entitled, “1365-70126-0-7-2-WSU-CPWI-Draft”.

CPWI: Program Description

CPWI is a strategic, data-informed, community coalition model aimed at bringing together key local stakeholders to provide the needed infrastructure and support to successfully coordinate, assess, plan, implement, and evaluate youth substance use prevention services needed in their community. An overarching goal of CPWI is to support population-level change in the highest need communities across the state. The primary long-term outcome of interest for CPWI is reducing youth behavioral problems, especially underage drinking. Other outcomes of interest include other types of substance use, mental health, related risk factors, and school success.

CPWI is modeled after several evidence- and research-based coalition models that have been shown to reduce community-level youth substance use, as well as related risk factors (Chilenski, Frank, Summers, & Lew, 2019; Feinberg, Chilenski, Greenberg, Spoth, & Redmond, 2007; Feinberg, Jones, Greenberg, Osgood, & Bontempo, 2010; B. K. E. Kim, Gloppen, Rhew, Oesterle, & Hawkins, 2015; Shrestha, Hill, & Cooper, 2019). CPWI uses a community coalition model as a prevention strategy to foster community ownership of prevention efforts and to increase the sustainability of prevention programs. CPWI is aligned with the federal Department of Health and Human Services' National Prevention Strategy, which aims to promote health and wellbeing among individuals, families, and communities in the United States.

The Washington State Health Care Authority (HCA) / Division of Behavioral Health and Recovery (DBHR) started CPWI in 2011 as a new funding approach to prioritize allocation of prevention funds to traditionally underserved, high-need communities throughout the state. Beginning in 2009, DBHR started CPWI-related meetings and discussions with counties, Office of Superintendent of Public Instruction (OSPI), educational service districts, and other stakeholders. CPWI replaced DBHR's prior funding approach in which prevention funding was allocated to counties. DBHR has partnered with state agencies, counties, schools, and prevention coalitions to implement CPWI. CPWI is funded by a federal block grant, discretionary grant funds, and the State Dedicated Marijuana Account.

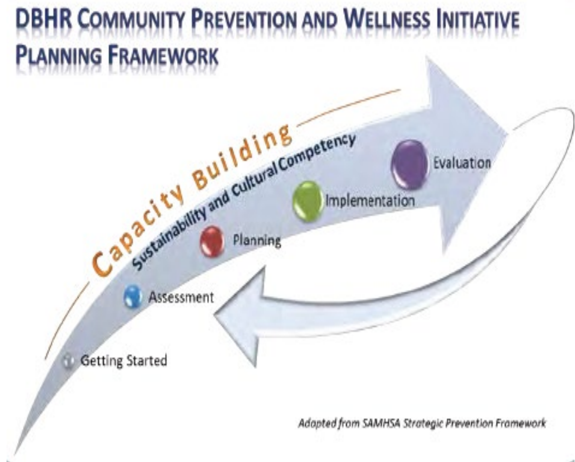
DBHR has developed extensive guidelines for community selection and program implementation. CPWI communities are selected based on a) risk scores computed from key substance use and consequence indicators, and b) community readiness to address its needs. See Appendix B for a list of CPWI communities.

All CPWI communities are required to represent 8 of the 12 sectors of the community in their coalition membership: youth under the age of 18, parents, law enforcement, civic/volunteer groups, businesses, healthcare professionals, media, schools, youth-serving organizations, religious/fraternal organizations, state/local/tribal governments, and other substance use prevention organizations.

DBHR has adapted Substance Abuse and Mental Health Services Administration (SAMSHA)'s Strategic Prevention Framework (SPF) for CPWI planning purposes. DBHR has added a "Getting Started" component to the SPF and expects "Capacity Building" to be an ongoing effort

throughout the CPWI planning and implementation process. In addition, CPWI communities are expected to conduct programs in a culturally competent manner and maintain a long-term vision for sustainability during planning and implementation efforts.

Each CPWI community coalition is required to implement an environmental strategy, a public awareness campaign, and direct services targeting youth substance use. A certain percentage of these programming efforts must be evidence-based programs, practices, or policies per contract terms. Each community is additionally required to implement capacity building activities. Every CPWI site includes, at a minimum, a 0.5 FTE Community Coordinator, as well as a 1.0 FTE school-based Student Assistance Professional (SAP).[4]



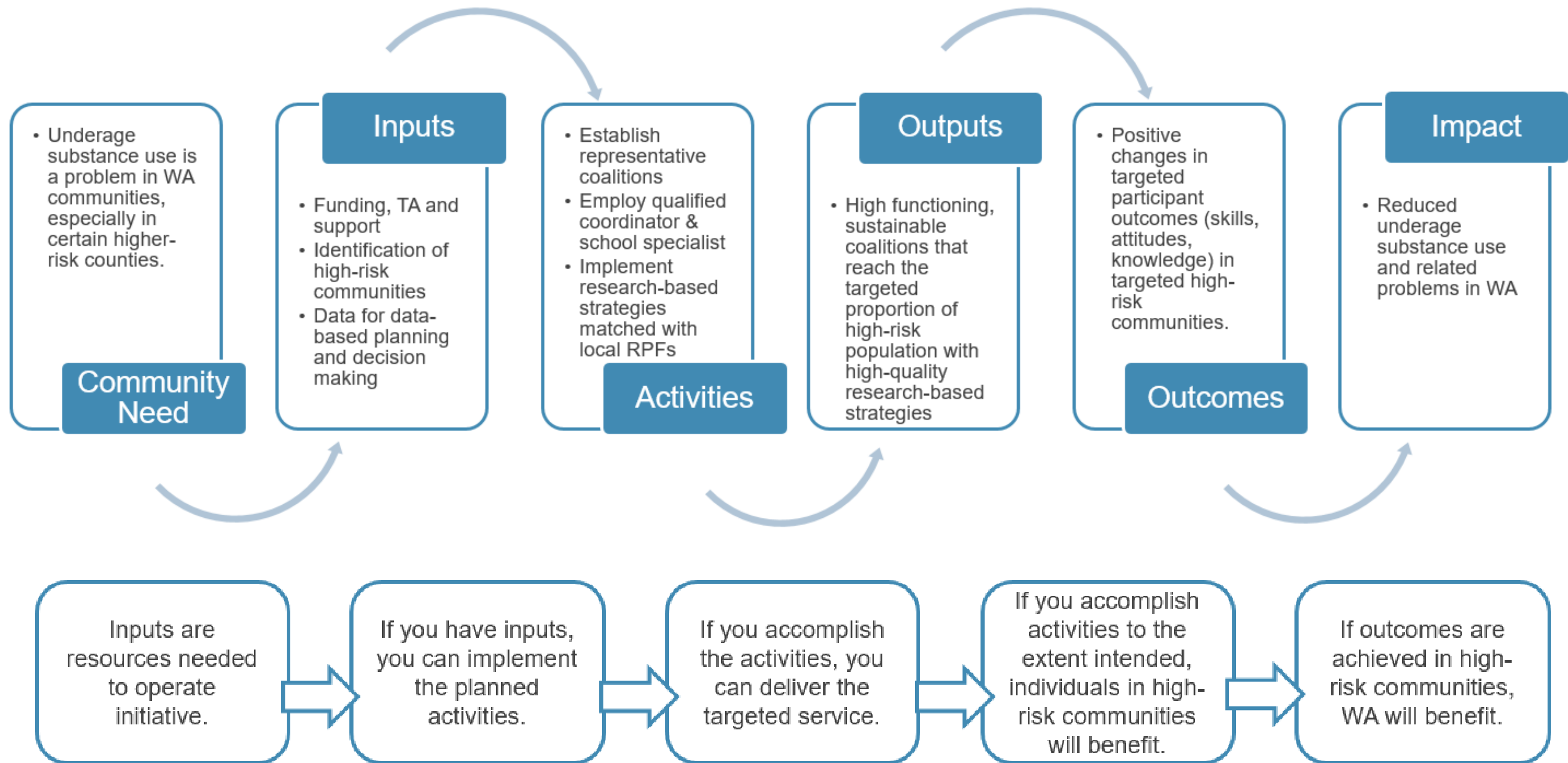
CPWI communities receive training, technical assistance, and support from DBHR staff in coalition development, strategic planning, evaluation, reporting, public awareness, social marketing, substance use prevention science, and mental health promotion.

Currently, there are 100 high-need communities in various stages of CPWI implementation in all 39 counties and across all 9 educational service districts in Washington State.

- Cohort 1 sites began implementing CPWI in 2011 and include 19 communities.
- Cohort 2 sites began implementing CPWI in 2012 and include 13 communities.
- Cohort 3 sites began implementing CPWI in 2013 and include 19 communities.
- Cohort 4 sites began implementing CPWI in 2016 and include 6 communities.
- Cohort 5 sites began implementing CPWI in 2017 and include 6 communities.
- Cohort 6 sites began implementing CPWI in 2018 and include 18 communities.
- Cohort 7 sites began implementing CPWI in 2021 and include 19 communities.

[4] Cohort 7 communities will have a full-time community coordinator to organize and manage the coalition.

CPWI Theory of Change: Bird's Eye View



RE-AIM Framework

The RE-AIM framework is a comprehensive planning and evaluation tool for complex, multi-component, multi-level initiatives (Compernolle et al., 2014; Grant, Treweek, Dreischulte, Foy, & Guthrie, 2013; Rabin et al., 2018; Viester, Verhagen, Bongers, & van der Beek, 2014). **RE-AIM is an acronym for the framework's 5 dimensions** considered most relevant for real-world implementation and dissemination of initiatives: a) Reach; b) Effectiveness; c) Adoption; d) Implementation; and e) Maintenance. The RE-AIM framework not only focuses on program *effectiveness*, but also on the degree to which a program can be *adopted* and disseminated widely, have consistent *implementation* at a reasonable cost across settings to *reach* a large number of the target population, and have the ability to be *maintained* or sustained over time (Glasgow, 2006; Glasgow, Vogt, & Boles, 1999; Harden et al., 2018; Kessler et al., 2013). Thus, each dimension of the RE-AIM framework guides program planning and evaluation efforts.

Table 1. Details of the RE-AIM Framework

RE-AIM Dimension	Description	Level
*R*each	Absolute number, proportion, and representativeness of targeted participants	Individual
*E*ffectiveness	Outcomes for participants, including potential negative outcomes	Individual
*A*doption	Absolute number, proportion, and representativeness of targeted settings (such as organizations, and communities) and intervention agents (such as teachers) willing to adopt the program	Organization
*I*mplementation	Quality of delivery, fidelity, adaptations, costs	Organization
*M*aintenance	Sustainability of program outcomes	Individual
	Sustainability of program and practices	Organization

These 5 dimensions of RE-AIM enhance the understanding of the "who, what, when, where, how, and why" of an initiative (Glasgow & Estabrooks, 2018):

- Who was intended to benefit and who actually participated or was exposed to the interventions?
- What were the most important benefits and what were the negative outcomes?
- Where was the program or policy applied (and who applied it)?
- How consistently was the program or policy delivered, what adaptations to the original plans were made, and how much did it cost?
- When did the initiative become fully operational, how long do results last, and how long was the initiative sustained?
- Why did the results come about?

This framework is one of the most popular planning and evaluation tools available. Since the publication of the RE-AIM framework in 1999, over 430 published studies have used the framework for planning and evaluation purposes (Holtrop, Rabin, & Glasgow, 2018). The

widespread use of the RE-AIM framework is also demonstrated by the fact that it is the most frequently used framework between 2000 and 2016 for Dissemination & Implementation grant applications submitted to the National Institutes of Health (NIH) and Centers for Disease Control and Prevention (CDC) (Harden et al., 2018). RE-AIM has been used across a variety of settings such as healthcare, schools, and communities to evaluate a wide variety of outcomes, including coalition and substance use prevention and treatment outcomes. See Table 2 below.

Table 2. Studies Using the RE-AIM Framework

Outcomes	Citations
Partnerships/coalitions	(Sweet, Ginis, Estabrooks, & Latimer-Cheung, 2014)
Substance use prevention and treatment	(Anderson et al., 2017; Bottorff et al., 2017; Hagedorn et al., 2014; A. E. Kim et al., 2012; Meyer et al., 2012; Payne et al., 2011; Reid et al., 2010; Rohrbach, Gunning, Sun, & Sussman, 2010; Stearns, Nambiar, Nikolaev, Semenov, & McIntosh, 2014)
Disease prevention and management	(Aziz, Riddell, Absetz, Brand, & Oldenburg, 2018; Brunisholz et al., 2017; Heitkemper, 2017; Santos et al., 2017)
Injury prevention	(Collard, Chinapaw, Verhagen, & van Mechelen, 2010; Li, 2013)
Nutrition	(Dunton, Lagloire, & Robertson, 2009; King, Glasgow, & Leeman-Castillo, 2010; Larsen et al., 2017)
Physical activity	(Bopp et al., 2007; Dunton et al., 2009; King et al., 2010)
Weight loss	(Akers, Estabrooks, & Davy, 2010; Compernolle et al., 2014; Kahwati, Lance, Jones, & Kinsinger, 2011)
Women's health	(Farris, Will, Khavjou, & Finkelstein, 2007; Maru et al., 2018)

A major strength of the RE-AIM framework is that it allows for flexibility in its application. Though it is ideal to employ the full RE-AIM model to assess the overall public health impact of an intervention, measuring all five RE-AIM dimensions may not be applicable, relevant, or feasible in some situations (Kessler et al., 2013). For instance, the evaluation of all RE-AIM dimensions in a community setting is potentially infeasible because of cost considerations and unavailability of necessary data. Thus, depending on intervention objectives and contextual factors, it may be more pragmatic for community interventions to focus on some dimensions, or to evaluate some dimensions in greater detail than others (Estabrooks & Allen, 2013). The flexible and pragmatic nature of RE-AIM framework makes it a well-suited tool for evaluating a complex, multi-faceted initiative such as CPWI.

Effectiveness Evaluation

The overarching goal of Effectiveness Evaluation is to measure program effects on outcomes of interest in the target population (Centers for Disease Control and Prevention [CDC], n.d.). As the name implies, these analyses address the *Effectiveness* dimension of the RE-AIM framework.

In this section, we provide an evaluation plan related to the following deliverable categories/reports:

I. Impact Over Time Analysis Substance Use Outcomes Report
II. Impact Over Time Analysis School Outcomes Report

I. Impact Over Time Analysis Substance Use Outcomes Report

The overarching purpose of the Impact Over Time Analysis is to assess the effectiveness of CPWI in reducing substance use and related risk factors and in improving protective factors among 10th graders in CPWI communities.

Outcomes of Interest

All outcomes of interest are from Healthy Youth Survey (HYS). We will examine 25 outcomes. All 25 outcomes are the same as the ones in the 2019 Impact Over Time Analysis Report.[5] The 2019 report along with the 2022 Impact Over Time Analysis Report will provide an opportunity to compare results for Cohorts 1-5 communities, and will also provide a basis for comparison for the newer cohorts.

Table 3. Outcomes of Interest for Impact Over Time Analysis Substance Use Outcomes Report

Domain	Outcomes
1. Alcohol	a. Any alcohol use ever b. Any alcohol use in past 30 days c. Frequency of alcohol use in past 30 days d. Any binge drinking in past 2 weeks
2. Cigarette	a. Any cigarette smoking ever b. Any cigarette smoking in past 30 days c. Frequency of cigarette smoking in past 30 days
3. Marijuana	a. Any marijuana use ever b. Any marijuana use in past 30 days c. Frequency of marijuana use in past 30 days
4. Prescription drug misuse	a. Any prescription drug misuse in past 30 days b. Frequency of prescription drug misuse in past 30 days

Note. Table continued on next page.

[5] The 2019 report also includes 6 school-specific outcomes. These outcomes will be analyzed separately in the Impact Over Time Analysis School Outcomes Report.

Table 3. Continued

Domain	Outcomes
5. Peer-individual risk factors	a. Low social skills b. Early initiation of substance use c. Friends' substance use d Favorable attitudes towards drug use e. Low perceived risk of substance use
6. Family risk factors	a. Low opportunities for prosocial involvement b. Parental attitudes favorable towards drug use c. Poor family management
7. Community risk factors	a. Low opportunities for prosocial involvement b. Laws and norms favorable to drug use c. Perceived availability of drugs
9. School protective factors	a. Services for students with ATOD problems b. People at school to help if students need help

Data Sources

We will use data from 5 sources. See the table below for description of each data source.

Table 4. Data Sources for Impact Over Time Analysis Substance Use Outcomes Report

Source	Description	Notes
Healthy Youth Survey (HYS)	HYS is a self-reported measure administered every two years to students in 6th, 8th, 10th, and 12th grade in approximately 1,000 public schools in Washington State. HYS is anonymous at the student level, but the data is identifiable at the school- and school district-level. We will use HYS 2008 to 2018 in our evaluation.	This data will be used in the propensity score model and the multilevel outcome model.
Risk and Protective Profile for Substance Abuse Prevention in Washington[a]	This data, compiled by Washington State Department of Social and Behavioral Health Services' Division of Research and Data Analysis (DSHS/RDA), is a comprehensive collection of data on youth substance use and related risk factors.	This data will be used in the propensity score model.
American Community Survey (ACS) [a]	ACS is an ongoing survey administered by the U.S. Census Bureau to collect yearly information on diverse topics including demographic, housing, economic, and social indicators. Yearly and 3-year ACS estimates are not available for a majority of school districts, so we will use district-level 5-year estimates.	This data will be used in the propensity score model.

[a] Data from these sources will be used in the propensity score model.
Note. Table continued on next page.

Table 4. Continued

Source	Description	Notes
Population and Housing Data[a]	This data, generated by the Washington State Office of Financial Management, Forecasting and Research Division (OFM/FRD), provides population estimates based on the 2010 Census.	This data will be used in the propensity score model.
Washington State Department of Revenue School District Levies Due[a]	The School District Levies Due data are compiled by the Washington State Department of Revenue.	This data will be used in the propensity score model.

[a] Data from these sources will be used in the propensity score model.

Study Design

We will use a cross-sectional design to assess outcomes at two time points: a) baseline, and b) post-intervention time point. The baseline for the cohorts are as follows:

- Cohort 1: 2008
- Cohort 2: 2010
- Cohort 3: 2010
- Cohort 4: 2014
- Cohort 5: 2016
- Cohort 6: 2016
- Cohort 7: 2018

The post-intervention time point is 2021 (i.e., we will use HYS 2021 data).[6]

Community is defined by its school district or its high school attendance area (HSAA). We focused on outcomes for 10th graders because previous years of Healthy Youth Survey data show that the most significant increase in substance use occurs between 8th and 10th grades, so 10th grade serves as a good "sentinel" age group. We will use propensity score weighted multi-level modeling to analyze the data. See Appendix C on propensity score analysis and Appendix D for multilevel modeling.

Covariates of Interest

We will control for baseline and other differences between CPWI and non-CPWI Washington communities. In our analyses, we will include the following covariates:

[6] Cohort 7 communities will start program implementation in Spring 2022.

Table 5. Covariates for the Propensity Score Model

Model	Domain	Variable	Source
Propensity score model	Demographics	a. Population density	Population Data
		b. Total population	ACS
	School performance	a. Self-reported truancy	HYS
	Youth delinquency	a. Self-reported fighting	HYS
		b. Carrying a weapon	HYS
		c. Gang involvement	HYS
		d. Driving under influence	HYS
	Mental Health	a. Depression	HYS
		b. Considering suicide	HYS
		c. Suicide attempts	HYS
	Economic	a. Median household income	ACS
		b. TANF child recipients	Risk Profile
		c. Food stamps recipients	Risk Profile
		d. Free and reduced lunch students	Risk Profile
		e. School district levies due	Dept. of Revenue
	Geographic location	a. Community location	Self-coded
Multilevel model	Demographics	a. Student gender	HYS
		b. Student race/ethnicity	HYS
		c. Intervention status	Self-coded

Evaluation Questions and Analyses

Impact Over Time Analyses focus on three questions:

1. Did 10th grade outcomes of interest change in CPWI communities from baseline to post-intervention time point?
    - We will calculate percent change from baseline to post-intervention time point for CPWI communities.

2. Did CPWI communities differ significantly from non-CPWI Washington communities in outcomes of interest at baseline and post-intervention time point?
    - We will compare CPWI communities with non-CPWI Washington communities (i.e., non-CPWI communities used as control group) by using a two-step analytic process.
    - In step 1, we will conduct propensity score analysis to adjust for differences between CPWI communities and other similar Washington communities. We will use propensity score weighting to balance baseline differences between CPWI and other similar Washington communities.
    - In step 2, we will conduct multilevel modeling to examine whether CPWI communities closed the gap in their level of risk at post-intervention time point.

3. Are trends across time different for CPWI communities than for Washington statewide?

- We will compare trends across time for CPWI communities with Washington trends.

Communication Tool

We will develop a communication tool based on the evaluation results. This tool will be designed to incorporate prevention messaging and data visualization best practices. We will consult with data visualization expert as well as DBHR staff to decide the best format (such as PowerPoint presentation, data dashboard, one-page handout, infographics) for the communication tool.

Output

The work products from this evaluation are as follows:
- Draft report
- Final report
- Communication tool

Timeline and Deliverables

Table 6. Timeline for Impact Over Time Analysis Substance Use Outcomes Report

SOW Item #	Deliverable	Estimated Due Dates
2.3a	Draft: Impact Over Time report substance use and related risk factors (HYS 2021)	Fall, 2022
2.3b	Final: Impact Over Time report substance use and related risk factors (HYS 2021)	Fall, 2022
2.3c	Impact Over Time communication tool	Fall, 2022

Status: On hold

The work on this deliverable will begin after Washington State University (WSU) receives HYS 2021 data.

Next Steps

- We will leverage monthly and quarterly DBHR-WSU meetings to provide updates on the evaluation deliverables and get feedback from DBHR. We will schedule additional meetings as needed.

II. Impact Over Time Analysis School Outcomes Report

The overarching purpose of the Impact Over Time Analysis School Outcomes evaluation is to assess the effectiveness of CPWI in improving school-related outcomes such as graduation rates, grades, and attendance, and in reducing dropout rates.

Outcomes of Interest

We will examine 6 outcomes. Outcomes of interest are from Washington State Office of Superintendent of Public Instruction (OSPI) and HYS.

Table 7. Outcomes of Interest for Impact Over Time Analysis School Outcomes Report

Outcome	Data Source
Attendance	HYS
Grades	HYS
Adjusted 4-year cohort graduation rate	OSPI
Adjusted 5-year cohort graduation rate	OSPI
Adjusted 4-year cohort dropout rate	OSPI
Adjusted 5-year cohort dropout rate	OSPI

Data Sources

We will use data from 6 sources. See the table below for description of each data source.

Table 8. Data Sources for Impact Over Time Analysis School Outcomes Report

Source	Description	Notes
Healthy Youth Survey (HYS)	HYS is a self-reported measure administered every two years to students in 6th, 8th, 10th, and 12th grade in approximately 1,000 public schools in Washington State. HYS is anonymous at the student level, but the data is identifiable at the school- and school district-level. We will use HYS 2008 to 2018 in our evaluation.	This data will be used in the propensity score model and the multilevel outcome model.
Risk and Protective Profile for Substance Abuse Prevention in Washington[a]	This data, compiled by Washington State Department of Social and Behavioral Health Services' Division of Research and Data Analysis (DSHS/RDA), is a comprehensive collection of data on youth substance use and related risk factors.	This data will be used in the propensity score model.

[a] Data from these sources will be used in the propensity score model.
Note. Table continued on next page.

Table 8. Continued

Source	Description	Notes
American Community Survey (ACS) [a]	ACS is an ongoing survey administered by the U.S. Census Bureau to collect yearly information on diverse topics including demographic, housing, economic, and social indicators. Yearly and 3-year ACS estimates are not available for a majority of school districts, so we will use district-level 5-year estimates.	This data will be used in the propensity score model.
Population and Housing Data[a]	This data, generated by the Washington State Office of Financial Management, Forecasting and Research Division (OFM/FRD), provides population estimates based on the 2010 Census.	This data will be used in the propensity score model.
Washington State Department of Revenue School District Levies Due[a]	The School District Levies Due data are compiled by the Washington State Department of Revenue.	This data will be used in the propensity score model.

[a] Data from these sources will be used in the propensity score model.

Study Design

We will use a cross-sectional design to assess outcomes at two time points: a) baseline, and b) post-intervention time point.

For HYS outcomes, the baseline for the cohorts are as follows:

- Cohort 1: 2008
- Cohort 2: 2010
- Cohort 3: 2010
- Cohort 4: 2014
- Cohort 5: 2016
- Cohort 6: 2016
- Cohort 7: 2018

The post-intervention time point is 2021 (i.e., we will use HYS 2021 data).

For OSPI outcomes, the baseline for the cohorts will be based on availability of OSPI data. Currently, the OSPI data portal includes graduation and dropout data from 2015 to 2020 only. The data portal states that older data may be available upon request.

The post-intervention time point is 2021 (data for 2021 is not available online as of July 26th, 2021).

Covariates of Interest

We will control for baseline and other differences between CPWI and non-CPWI Washington communities. In our analyses, we will include the following covariates:

Table 9. Covariates for the Propensity Score Model

Model	Domain	Variable	Source
Propensity score model	Demographics	a. Population density	Population Data
		b. Total population	ACS
	School performance	a. Self-reported truancy	HYS
	Youth delinquency	a. Self-reported fighting	HYS
		b. Carrying a weapon	HYS
		c. Gang involvement	HYS
		d. Driving under influence	HYS
	Mental Health	a. Depression	HYS
		b. Considering suicide	HYS
		c. Suicide attempts	HYS
	Economic	a. Median household income	ACS
		b. TANF child recipients	Risk Profile
		c. Food stamps recipients	Risk Profile
		d. Free and reduced lunch students	Risk Profile
		e. School district levies due	Dept. of Revenue
	Geographic location	a. Community location	Self-coded
Multilevel model	Demographics	a. Student gender	HYS
		b. Student race/ethnicity	HYS
		c. Intervention status	Self-coded

Evaluation Questions and Analyses

Impact Over Time Analyses focus on three questions:

1. Did 10th grade outcomes of interest change in CPWI communities from baseline to post-intervention time point?
    - We will calculate percent change from baseline to post-intervention time point for CPWI communities.

2. Did CPWI communities differ significantly from other similar Washington communities in outcomes of interest at baseline and post-intervention time point?
    - We will compare CPWI communities with other similar Washington communities (i.e., non-CPWI communities used as control group) by using a two-step analytic process.
    - In step 1, we will conduct propensity score analysis to adjust for differences between CPWI communities and other similar Washington communities. We will

use propensity score weighting to balance baseline differences between CPWI and other similar Washington communities.
    - In step 2, we will conduct multilevel modeling to examine whether CPWI communities closed the gap in their level of risk at post-intervention time point.

3. Are trends across time different for CPWI communities than for Washington statewide?
    a. We will compare trends across time for CPWI communities with Washington trends.

Communication Tool

We will develop a communication tool based on the evaluation results. This tool will be designed to incorporate prevention messaging and data visualization best practices. We will consult with data visualization expert as well as DBHR staff to decide the best format (such as PowerPoint presentation, data dashboard, one-page handout, infographics) for the report.

Output

The work products from this evaluation are as follows:
- Draft report
- Final report
- Communication tool

Timeline and Deliverables

Table 10. Timeline for Impact Over Time Analysis School Outcomes Report

SOW Item #	Deliverable	Estimated Due Dates
2.2a	Draft: Impact Over Time report	Summer 2022
2.2b	Final: Impact Over Time report	Summer 2022
2.2c	Impact Over Time communication tool	Summer 2022

Status: On hold

The work on this deliverable will start after the submission of the final version of this evaluation plan.

Next Steps
- Explore the OSPI data portal and the available graduation/dropout data files to create a data cleaning plan. We used the OSPI data files in 2019 to get graduation and dropout data. The OSPI data portal has been updated to a different format. So, we need to explore the new portal and data files to plan the analysis and to prepare the data for

analysis (i.e., merging with HYS data, conducting propensity score weighted analysis etc.).

- Request older data files as needed.
- Schedule a meeting with DBHR to discuss this evaluation. During this meeting, we will work with DBHR to determine when and how to consult with OSPI staff and representatives from ESDs. It is important to note that the timing of our meetings/consultations with OSPI and ESD personnel could affect the timeline of the deliverable.
- Request Cohort 7 community names, school district names, HYS codis numbers, High School Attendance Area (HSAA) names, school names, and HYS school numbers so that we can start recoding CPWI and non-CPWI communities in HYS data.

Implementation Evaluation

The overarching purpose of the implementation evaluation is to determine whether CPWI procedural objectives have been met, and to identify areas for further development as well as lessons learned. The implementation evaluation also includes the assessment of factors that affect implementation such as capacity building.

In this section, we provide a brief plan related to the following deliverable categories/reports:

I. Capacity-Building Evaluation Report
II. SAMHSA-PFS Evaluation Report

I. Capacity-Building Evaluation Report

The purpose of the CPWI Cohort 7 Expansion contract (RFA No. 2021HCA4) is to increase the capacity of Cohort 7 communities to implement direct and environmental substance use disorder (SUD) prevention services in communities to prevent and reduce the misuse of substances. In accordance with the CPWI Cohort 7 Expansion contract, this evaluation will focus on assessing whether capacity building has increased in Cohort 7 communities.

The expected time period for the contract is July 1, 2021 to March 14, 2023. In our evaluation of CPWI, we have used the RE-AIM framework to carry out evaluation activities. Capacity-building can be considered an important contextual factor that can affect the five RE-AIM dimensions. Capacity-building has several dimensions such as leadership, resource mobilization, and partnership (Brownson et al., 2018; Goodman et al., 1998; Liberato et al., 2011). We will use the Coalition Assessment Tool and the Coalition Progress Questionnaire to measure capacity building in Cohort 7 communities.

Coalition Assessment Tool[7]

The Coalition Assessment Tool (CAT) is a quantitative, self-assessment survey filled out by coalition members on their coalition's characteristics (see Appendix B for measure). CAT is administered every October, and it assesses 14 coalition characteristics:

1) Vision, mission and goals
2) Coalition structure and membership
3) Coalition leadership
4) Outreach and communication
5) Coalition meetings and communication
6) Opportunities for member growth and responsibility
7) Effectiveness in planning and implementation
8) Relationship with local government and other community leaders
9) Partnerships with other organizations
10) Coalition members' sense of ownership and participation

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[7] Source of the measure is Vermont and the Strategic Prevention Framework State Incentive Grant (SPF-SIG) evaluation.

11) Ability to collect, analyze, and use data
12) Understanding of and commitment to environmental change strategies
13) Cultural competence
14) Funding and sustainability

Coalition Progress Questionnaire[8]
The Coalition Progress Questionnaire (CPQ) is a two-step measure designed to gather information on a coalition's development and progress, its technical assistance (TA) and training needs, as well as its implementation of CPWI (see Appendix C for measure). First, DBHR Prevention System Managers (PSMs) use the questionnaire shown in Appendix C to facilitate a conversation with the coalition coordinator about the current status of the coalition's implementation of CPWI. Then based on the information gathered from the conversation, the PSMs fill out the CPQ survey in which they rank the coalitions from 1 (lowest rank) to 6 (highest rank) on each question. The CPQ is administered in spring; thus, over time, the PSM rankings can be compared to assess the progress of the coalitions. For Cohort 7 communities, the CPQ will be administered in October 2021 to get baseline data. See Appendix E for the measures.

We will measure capacity building at 3 time points to assess change in Cohort 7 communities.
At baseline: October 2021
At mid-point: TBD after discussing with DBHR
At the end of the contract period: March 2023

A draft of the measures and plan of analysis is due to DBHR in Fall 2021 (see Table 11 for details).

Output

The work products from this evaluation are as follows:
- Measures
- Plan of analysis
- Codebook
- Draft report
- Final report

[8] DBHR received consultation from the Community Anti-Drug Coalitions of America (CADCA) during the development of this measure.

Timeline and Deliverables

Table 11. Timeline for Capacity-Building Evaluation

SOW Item #	Deliverable	Estimated Due Dates
7.1a	Draft: Measures & plan of analysis	Fall 2021 (after 9/30/2021)
7.1b	Final: Measures & plan of analysis	Fall 2021 (after 9/30/2021)
7.1c	Data cleaning and preparation, codebook	Spring 2023
7.1d	Draft: Cohort 7 capacity-building evaluation	Spring 2023
7.1e	Final: Cohort 7 capacity-building evaluation	Spring 2023

Status: In planning

Next Steps

- Meet with DBHR to review measures and decide next steps.

II. SAMHSA-PFS Evaluation Report [9]

The purpose of SAMHSA-PFS evaluation is to assess the implementation and effectiveness of CPWI programming in PFS grantee communities and to fulfill PFS grant requirements.

There are two specific work items under this category:

a. SAMHSA-PFS 2018 Evaluation Report Year 3
b. SAMHSA-PFS 2018 Evaluation Report Year 4

II.a. SAMHSA-PFS 2018 Evaluation Report Year 3

This report will focus on 18 PFS-funded communities, and it covers Year 3 of the PFS-2018 grant (Sept 30, 2020-Sept 29, 2021).

Study Design

This report will broadly focus on CPWI implementation evaluation in PFS communities and in PFS schools through Project SUCCESS.[10] We will use descriptive statistics (i.e., frequency count) to answer the evaluation questions.

Data Sources

We will use data from 2 sources. See the table below for description of each data source.

Table 12. Data Sources for SAMHSA-PFS 2018 Evaluation Report Year 3

Source	Description
Substance Use Disorder Prevention and Mental Health Promotion Online Reporting System (Minerva)	This management information system is used by DBHR contractors to report on prevention services. Minerva has planning, demographic, implementation, and pre-post data for programs and services.
Washington State Office of Superintendent of Public Instruction Project SUCCESS database	This web-based system is used to document and track prevention activities implemented in schools through Project SUCCESS

[9] We have listed SAMHSA-PFS report under “Implementation Evaluation” rather than “Effectiveness Evaluation” because the reports for Year 1 to Year 3 focus only on implementation evaluation (post-intervention outcome data not available for these years). PFS communities started implementation in November 2018. So, post-intervention outcome data will not be available until the administration of the HYS 2021 survey in October. The questions for Year 4 outcome evaluation will be from the Impact Over Time Analysis Substance Use Outcomes Evaluation.
[10] PFS Year 3 annual report will not include outcome evaluation data because we do not have post-intervention HYS data for Year 3 (Sept 30, 2020 to Sept 29, 2021).

Evaluation Questions

1. How many programs/activities were implemented?
2. What types of programs/activities were implemented in the following categories?
   - We will calculate programs based on the following categorizations:
     - i. Center for Substance Abuse Prevention (CSAP) strategies
     - ii. DBHR classification
     - iii. Institute of Medicine (IOM) classification
     - iv. OSPI classification for Project SUCCESS universal activities
3. Are the implemented programs evidence-based?
4. What risk and protective factors related to adolescent substance use are the primary targets?
5. How many participants received prevention programs/activities?
   - We will calculate the reach of the programs implemented in the communities for the following categories:
     - i. Population-level programs
     - ii. Aggregate programs
     - iii. Individual programs
   - We will calculate the reach of the program implemented in the schools for the following categories:
     - i. Universal activities
     - ii. Indicated activities
   - We will calculate demographic breakdown of the participants based on their gender and race/ethnicity.
6. How do the results from this year compare with results from previous years?
   - Include results from previous years for comparison purposes.

Communication Tool

Not applicable.

Output

The work products from this evaluation are as follows:

- Draft report
- Final report

Timeline and Deliverables

Table 13. Timeline for SAMHSA-PFS 2018 Evaluation Year 3

SOW Item #	Deliverable	Estimated Due Dates
2.1a	Draft FFY 2018 SAMHSA-PFS annual evaluation (Year 3 Report)	11/2021
2.1b	Final FFY 2018 SAMHSA-PFS annual evaluation (Year 3 Report)	12/2021

Status: On hold

The work on this deliverable will begin after WSU receives data from DBHR.

Next Steps

- Request data from DBHR.

II.b. SAMHSA-PFS 2018 Evaluation Report Year 4

This report will focus on 18 PFS-funded communities, and it covers Year 4 of the PFS-2018 grant (Sept 30, 2021-Sept 29, 2022).

Study Design

This report will broadly focus on CPWI implementation evaluation in PFS communities and in PFS schools through Project SUCCESS. We will use descriptive statistics (i.e., frequency count) to answer the evaluation questions. Year 4 report will also include results from the outcome evaluation of CPWI (i.e., results for Cohort 6 communities which are funded by PFS). Similarly, this report will include results from previous years.

Data Sources

We will use data from 3 sources. See the table below for description of each data source.

Table 14. Data Sources for SAMHSA-PFS 2018 Evaluation Report Year 4

Source	Description
Substance Use Disorder Prevention and Mental Health Promotion Online Reporting System (Minerva)	This management information system is used by DBHR contractors to report on prevention services. Minerva has planning, demographic, implementation, and pre-post data for programs and services.
Washington State Office of Superintendent of Public Instruction Project SUCCESS database	This web-based system is used to document and track prevention activities implemented in schools through Project SUCCESS
Impact Over Time Evaluation (HYS 2021)	The outcome evaluation for PFS-funded communities will focus on the effectiveness of CPWI in reducing substance use and related risk factors and in improving protective factors, among 10th graders in CPWI communities

Evaluation Questions

The questions for implementation evaluation are the same as in PFS Year 3 evaluation. The questions for outcome evaluation are from the Impact Over Time Analysis Substance Use Outcomes Evaluation.

Communication Tool

Not applicable.

Output

The work products from this evaluation are as follows:

- Draft report
- Final report

Timeline and Deliverables

Table 15. Timeline for SAMHSA-PFS 2018 Evaluation Year 4

SOW Item #	Deliverable	Estimated Due Dates
2.5a	Draft FFY 2018 SAMHSA-PFS annual evaluation (Year 4 Report)	11/2022
2.5b	Final FFY 2018 SAMHSA-PFS annual evaluation (Year 4 Report)	12/2022

Status: On hold

The work on this deliverable will begin in Fall 2022.

Next Steps

- None.

RE-AIM Evaluation Report

The overarching purpose of the RE-AIM report is to determine the macro level public health impact of CPWI using the RE-AIM Framework.

Outcomes of Interest

The outcomes of interest are the 5 RE-AIM dimensions: Reach, Effectiveness, Adoption, Implementation, and Maintenance.

Data Sources

We will use data from 3 sources. See the table below for description of each data source.

Table 16. Data Sources for the RE-AIM Evaluation

Source	Description
Substance Use Disorder Prevention and Mental Health Promotion Online Reporting System (Minerva)	This management information system is used by DBHR contractors to report on prevention services. Minerva has planning, demographic, implementation, and pre-post data for programs and services. Minerva provides data for the Implementation and Reach dimensions.
CPWI Impact Over Time Evaluation Data	This evaluation will be conducted in 2021. The purpose of the evaluation is to assess the effectiveness of CPWI in reducing adolescent substance use and related risk factors. CPWI Impact Over Time Evaluation provides data for the Effectiveness dimension.
CPWI Process Evaluation Data	TBD.

Study Design

We will evaluate the CPWI cohorts across the RE-AIM dimensions. The operationalization of Effectiveness and Implementation dimensions are as follows:

- Effectiveness: Proportion of outcomes in which CPWI cohorts showed improvements from baseline to post-intervention time point. We will select the outcomes based on our discussion with DBHR.
- Implementation: Proportion of evidence-based programs implemented in the communities.

The operationalization of the remaining dimensions (Reach, Adoption, and Maintenance) will depend on the availability of data.[11]

[11] The operationalization of these dimensions will depend on the questions included in the process evaluation.

To calculate the RE-AIM score for each cohort, we will compute a single qualitative summary score (high, medium, and low) on each dimension and color code the results to allow for a visual inspection of how the cohorts have functioned overall. The criteria to assign a summary score for Effectiveness and Maintenance are as follows[12]:

Table 17. Summary Score Criteria

Dimension	High	Medium	Low
Effectiveness	70% or more gaps closed	40% to 69% gaps closed	Fewer than 40% gaps closed
Implementation	80% of programs of higher are evidence-based	60% to 79% of programs are evidence-based	Fewer than 60% of programs are evidence-based (DBHR minimum threshold)

Evaluation Questions and Analyses

Reach

1. How many participants received prevention programs?
    a. Population-level programs
    b. Aggregate programs
    c. Individual programs

Effectiveness

1. Did CPWI communities close the gap in their level of risk compared to non-CPWI communities?

Implementation

1. How many programs were implemented by CPWI communities?
2. What types of programs were implemented by CPWI communities?
3. Are the implemented programs evidence-based?

The questions for Adoption and Maintenance will be decided based on the data from the Process Evaluation. Similarly, any additional questions for Reach and Implementation will also be based on the data from the Process Evaluation or other sources DBHR identifies.

Communication Tool

We will develop a communication tool based on the evaluation results. This tool will be designed to incorporate prevention messaging and data visualization best practices. We will

[12] We will consult with DBHR to decide the criteria for receiving summary scores for the remaining dimensions.

consult with data visualization expert as well as DBHR staff to decide the best format (such as PowerPoint presentation, data dashboard, one-page handout, infographics) for the communication tool.

Output

The work products from this evaluation are as follows:

- Draft report
- Final report
- Communication tool

Timeline and Deliverables

Table 18. Timeline for the RE-AIM Evaluation

SOW Item #	Deliverable	Estimated Due Dates
2.4a	Draft RE-AIM evaluation	Summer 2023
2.4b	Final RE-AIM evaluation	Summer 2023
2.4c	RE-AIM report communication tool	Summer 2023

Status: On hold

The work on this deliverable will begin after WSU receives HYS 2021 data.

Next Steps

- None.

Dissemination Deliverables

In this section, we provide details related to the following dissemination categories:

I. National Conference Presentations
II. Regional or State Conference Presentations
III. Manuscripts
IV. Slide Deck of Completed Reports

I. National Conference Presentations

We plan on submitting abstract proposals to national conferences organized by one or more of the following organizations:

- Society for Prevention Research
- National Prevention Network
- Society for Implementation Research Collaboration
- American Evaluation Association
- Academy Health

Timeline and Deliverables

Table 19. Timeline for National Conference Presentations

SOW Item #	Deliverable	Estimated Due Dates
4.1a	FY 2021 national conference abstract submission	06/30/2022
4.1b	FY 2021 national conference presentation	06/30/2022
4.5a	FY 2022 national conference abstract submission	06/30/2023
4.5b	FY 2022 national conference presentation	06/30/2023

Next Steps

- Review the timing (abstract due dates and conference dates) and conference themes to determine which conferences to submit abstracts to fulfill the deliverables.

II. Regional or State Conference Presentations

Here are some potential regional or state conferences:

- WA State Prevention Summit/Provider Meeting
- Washington State University Academic Showcase
- Center for Rural Opioid Prevention, Treatment & Recovery (CROP+TR) webinar

Timeline and Deliverables

Table 20. Timeline for Regional or State Conference Presentations

SOW Item #	Deliverable	Estimated Due Dates
4.2a	FY 2021 regional or state conference abstract submission	06/30/2022
4.2b	FY 2021 regional or state conference presentation	06/30/2022
4.6a	FY 2022 regional or state conference abstract submission	06/30/2023
4.6b	FY 2022 regional or state conference presentation	06/30/2023

Next Steps

- Review the timing (abstract due dates and conference dates) and conference themes to determine which conferences to submit abstracts to fulfill the deliverables.

III. Manuscripts

Timeline and Deliverables

Table 21. Timeline for Manuscripts

SOW Item #	Deliverable	Estimated Due Dates
4.3	Developmental trend manuscript resubmission	12/30/2021
4.4a	Draft: RE-AIM evaluation manuscript	04/30/2022
4.4b	Final: RE-AIM evaluation manuscript	06/30/2022
4.7a	Draft: manuscript based on one of the reports (TBD)	04/30/2023
4.7b	Final: manuscript based on one of the reports (TBD)	06/30/2023

Status: In progress

We have received feedback on the developmental trend manuscript from two external reviewers. We are revising the manuscript based on their feedback.

Next Steps

- Developmental trend manuscript: Continue addressing external reviewer comments and make changes as needed.

IV. Slide Deck of Completed Reports

Timeline and Deliverables

Table 22. Timeline for Slide Deck of Completed Reports

SOW Item #	Deliverable	Estimated Due Dates
4.8	Slide deck of completed reports for presentations to stakeholders including legislators	Fall 2021

Status: In progress

We met with Dr. Lori Palen, who is the owner and principal consultant at Data Soapbox , on July 22nd to start preliminary discussion for data visualization.

Next Steps

- Meet with DBHR to identify priority set of reports to create slide deck.

Next Steps

In this section, we list the next steps for all variables:

Table 23. Next Steps for the Deliverables

Deliverable	Next Steps
2.3 Impact Over Time Analysis Substance Use Report	- There are no immediate next steps. The work on this deliverable will begin after we receive HYS 2021 data.
2.2 Impact Over Time School Outcomes Report	- Explore the OSPI data portal and the available graduation/dropout data files to create a data cleaning plan. We used the OSPI data files in 2019 to get graduation and dropout data. The OSPI data portal has been updated to a different format. So, we need to explore the new portal and data files to plan the analysis and to prepare the data for analysis (i.e., merging with HYS data, conducting propensity score weighted analysis etc.). - Request older data files from OSPI as needed. - Meet with DBHR to discuss this evaluation. During this meeting, we will work with DBHR to determine when and how to consult with OSPI staff and representatives from ESDs. It is important to note that the timing of our meetings/consultations with OSPI and ESD personnel could affect the timeline of the deliverable. - Request Cohort 7 community names, school district names, HYS codis numbers, High School Attendance Area (HSAA) names, school names, and HYS school numbers so that we can start recoding CPWI and non-CPWI communities in HYS data.
7.1 Capacity-Building Evaluation Report	- Meet with DBHR to review measures and decide next steps.
2.1 SAMHSA-PFS 2018 Evaluation Year 3 Report	- Request data from DBHR.
2.5 SAMHSA-PFS 2018 Evaluation Year 4 Report	- There are no immediate next steps.
2.4 RE-AIM Evaluation Report	- There are no immediate next steps.
4.1 FY 2021 National Conference Presentations 4.2 FY 2021 Regional or State Conference Presentation	- Review the timing (abstract due dates and conference dates) and conference themes to determine which conferences to submit abstracts to fulfill the deliverables.
4.5 FY 2022 National Conference Presentations 4.6 FY 2022 Regional or State Conference Presentations	- There are no immediate next steps.
4.3 Developmental trend manuscript resubmission	- Continue addressing external reviewer comments and make changes as needed.
4.8 Slide Deck of Completed Reports	- Meet with DBHR to identify priority set of reports to create slide deck.

We will leverage monthly and quarterly DBHR-WSU meetings to provide updates on the evaluation deliverables and get feedback from DBHR. We will schedule additional meetings as needed.

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Appendix A: Glossary of Analytical Terms

Cross-sectional analysis: A study design in which data is analyzed for a single point in time.

Descriptive statistics: Analysis designed to summarize or describe the data.

Inferential statistics: Analysis designed to determine relationship between variables with the goal of drawing conclusions or making predictions.

Mixed-method analysis: Research methodology which emphasizes the collection and systematic integration of both quantitative and qualitative data to answer the research questions.

Multilevel modeling: A statistical tool that accounts for the hierarchical or clustered nature of data such as students nested within schools.

Percent change: Calculation to determine the change in percentages between two values, and is usually used to assess change from Time 1 to Time 2.

Propensity score analysis: A statistical tool that accounts for selection bias by balancing potential confounders between intervention and control groups.

Propensity score weighted multilevel modeling: A statistical technique in which propensity score weights are added to the multilevel model. When propensity scores are calculated, individuals with higher propensity scores are overrepresented and individuals with lower propensity scores are underrepresented in the intervention group. The opposite is true for individuals in the control group. So, evaluators assign weights to individuals such that overrepresented individuals are down-weighted, and underrepresented individuals are up-weighted. The logic behind using IPTW is similar to assigning survey weights.

Repeated cross-sectional analysis: A study design in which data is collected repeatedly at regular intervals and analysis is conducted to study change over time.

Appendix B: CPWI Communities

The list of CPWI communities is as follows:
Cohort 1 Communities

1. Bellingham
2. Bethel
3. Central Seattle
4. Chimacum
5. Darrington
6. Ferndale
7. Long Beach
8. Marysville
9. Omak
10. Othello
11. Pasco SD
12. Sunnyside
13. Tacoma/Franklin Pierce
14. Tenino
15. Vashon Island
16. Washougal
17. Wenatchee
18. West Vancouver / Discovery
19. White Swan

Cohort 2 Communities

1. Bremerton
2. Castle Rock
3. Clarkston
4. Cle Elum/Roslyn
5. Dayton
6. Forks
7. Moses Lake
8. Oak Harbor
9. Reardan
10. South East Seattle
11. Stevenson
12. Tekoa
13. West Central

Cohort 3 Communities

1. Cathlamet
2. Clover Park
3. Concrete
4. Cusick
5. East Valley
6. Hoquiam
7. Klickitat/Lyle
8. Mary Walker/Springdale
9. Monroe
10. Morton
11. North Kitsap
12. Pomeroy
13. Prosser
14. Republic
15. San Juan
16. Shelton
17. Walla Walla
18. Waterville
19. White Center/Highline

Cohort 4 Communities

1. Auburn / Cascade
2. Chief Sealth
3. Crescent / Joyce
4. Wahluke
5. Wapato
6. Yakima SD

Cohort 5 Communities

1. Aberdeen
2. Mt Baker SD
3. Mt Vernon
4. South Bend
5. Tumwater
6. Wellpinit SD

Cohort 6 Communities

1. Benton City
2. Central Vancouver
3. Centralia
4. Cheney

5. Cowiche/Tieton (Highland)
6. Ellensburg
7. Goldendale
8. Kennewick
9. Longview
10. Newport
11. North Mason
12. Port Townsend
13. Quincy
14. Rogers HS
15. Sedro Woolley
16. Selkirk
17. Shadle Park
18. South Whidbey

Cohort 7 Communities

1. Lakewood School District
2. Sultan
3. Mountlake Terrace HS
4. Orting School District
5. Royal School District
6. Mabton School District
7. Granger School District
8. Port Angeles
9. Quilcene
10. Enumclaw
11. Soap Lake
12. Colfax
13. Kelso
14. Elma
15. Wilbur
16. Granite Falls
17. White Salmon
18. South Kitsap
19. College Place

Appendix C: Propensity Score Analysis Technical Details

Propensity score analysis is a statistical tool that accounts for selection bias by balancing potential confounders between intervention and control groups in a non-equivalent group design. A propensity score represents an individual's probability of receiving an intervention, conditional on observed baseline confounders. In interventions where community is the unit of assignment, as in the case of CPWI, a propensity score represents a community's probability of receiving an intervention. Evaluators can use propensity score techniques to model selection into intervention. Among the various techniques available in propensity score analysis to adjust for confounding, we will use propensity score weighting which is a technique used to create balance between intervention and control groups by assigning weights to individuals. We will then use propensity score weighting adjusted data to calculate CPWI effects in the multilevel models, as described below in Technical Appendix C.

Propensity score analysis includes data at the school district level for all communities that are defined by the school district. For communities that are defined by the HSAA, HYS data is at the school level but the data from other sources are at the school district level. We will use proc logistic syntax in SAS 9.4 statistical software to calculate propensity scores for each school district using data for 6th, 8th, 10th, and 12th grades. We will conduct balance test to assess whether propensity score weighting technique produced satisfactory balance across confounders.

Variables to be used in calculating propensity score	
Factor	Indicator
Substance use	Any alcohol use in past 30 days
	Frequency of alcohol use in past 30 days
	Any cigarette smoking in past 30 days
	Frequency of cigarette smoking in past 30 days
	Any marijuana use in past 30 days
	Frequency of marijuana use in past 30 days
School Performance	Self-reported truancy
Youth Delinquency	Self-reported fighting
	Carrying a weapon
	Gang membership
	Driving under influence
Mental Health	Depression
	Considering suicides
	Suicide attempts
Population	Population density
	Total population
	Rural or urban Location
Economic Indicators	TANF child recipients
	Food stamps recipients
	Median household income
	School district levies

SAS Syntax

Sample syntax for Cohort 1 (syntax will be updated with new outcomes and variables)

```
/* To calculate propensity score – all relevant variables have to be added to the model */
proc logistic data= z.hys_file_with_all_grades descending;
class CPWI;
model CPWI = S07_mean H41_mean H38_mean H42_all_mean H34_mean H53_mean
H54_mean H56_mean TANFaid_sdrate2008_mean Foodstamp_sdrate2008_mean
d20use_mean d20_mean d14use_mean d14_mean d21use_all_mean d21_all_mean
population_density_2010_mean median_household_income_mean total_pop_mean
re_location_mean schoollevy2008_mean /link=logit rsquare;
output out = z.predin predicted=predprob; /* predprob is name of propensity score variable */
run;

/* check overlap of propensity score */
proc sort data = z.predin; by cpwi; run;
options nodate;
ods pdf file = " C:\Desktop\cpwiboxplot _c1.pdf";
proc boxplot data=z.predin;
plot predprob* cpwi;
title 'Boxplots for logit propensity: CPWI Cohort1 vs non-CPWI';
run;
quit;
ods pdf close;
title; /* to clear the title */

options nodate;
ods pdf file = " C:\Desktop\histogram_c1.pdf";
proc univariate data=z.predin normal;
class cpwi;
var predprob; histogram /normal kernel;
title 'Histograms for propensity: CPWI Cohort1 vs Non-CPWI';
run;
quit;
ods pdf close;
title; /* to clear the title */

/* to check the range of predicted probabilities */
proc freq data=z.predin; tables predprob; by cpwi; run;

/* to calculate att weights, grade 10 only */
data z.iptw; set z.predin;
ipw_att=cpwi+(1-cpwi)*predprob/(1-predprob);
```

```
run;

/* to assess balance for propensity score att weights */
proc means data=z.iptw (where=(cpwi =0));
var S07_mean H41_mean H38_mean H42_all_mean H34_mean H53_mean H54_mean
H56_mean TANFaid_sdrate2008_mean Foodstamp_sdrate2008_mean d20use_mean
d20_mean d14use_mean d14_mean d21use_all_mean d21_all_mean
population_density_2010_mean median_household_income_mean total_pop_mean
re_location_mean schoollevy2008_mean;
weight ipw_att;
output out=baltx1(drop=_FREQ_ _TYPE_);
run;

proc transpose data=baltx1 out=tbaltx1 (rename= (_NAME_=NAME)); id _STAT_; run;

proc means data = z.iptw (where=(cpwi=1));
var S07_mean H41_mean H38_mean H42_all_mean H34_mean H53_mean H54_mean
H56_mean TANFaid_sdrate2008_mean Foodstamp_sdrate2008_mean d20use_mean
d20_mean d14use_mean d14_mean d21use_all_mean d21_all_mean
population_density_2010_mean median_household_income_mean total_pop_mean
re_location_mean schoollevy2008_mean;
weight ipw_att;
output out=baltx2 (drop=_FREQ_ _TYPE_);
run;

proc transpose data=baltx2 out=tbaltx2(rename=(_NAME_=NAME) rename=(MEAN=M2)
rename= (STD=STD2) rename= (N=N2) rename= (MIN=MIN2) rename= (MAX=MAX2));
id _STAT_;
run;

proc sort data=tbaltx1; by NAME; run;
proc sort data=tbaltx2; by NAME; run;

data z.bal_iptw; merge tbaltx1 tbaltx2; by NAME; run;
data z.bal_iptw; set z.bal_iptw; stdeff=(M2-MEAN)/STD2; run;

proc print data=z.bal_iptw; var name stdeff; run;
```

Appendix D: Multilevel Modeling Technical Details

We will run a two-level model with communities at level 2, and students at level 1. A majority of CPWI communities were defined by the school district, while a few were defined by the high school area. We will use proc mixed syntax in SAS 9.4 statistical software to conduct multilevel modeling. We will include student gender and race/ethnicity as covariates in our multilevel model. Program effect will be defined by a dichotomous variable representing participation in the program (CPWI vs. other).

The original coding of protective factors in HYS was 0=low protection/high risk, 1=high protection/low risk. In order to make the interpretation of the results easier, we will recode the protective factors as 0=high protection/low risk, 1= low protection/high risk. In other words, we will reframe protective factors as risk factors.

SAS Syntax

Sample syntax (syntax will be updated with new outcomes and variables)

```
/* multilevel model code for CPWI cohort 1 */
/* alcohol use prevalence d20 use */
ods pdf file = " C:\Desktop\1_2018_d20use_alcohol_prevalence.pdf";
proc mixed data=z.hys_2018_g10_c1covtest noitprint;
weight ipw_att;
class re_codis g06 gender cpwi;
model d20use=gender g06 cpwi /solution;
random intercept / sub=re_codis type=un;
lsmeans cpwi / cl pdiff;
title1 'Multilevel model for alcohol use prevalence';
title2 '2016 outcome for grade 10 students';
title3 'CPWI Cohort1 vs. non-CPWI school districts';
run;
title;
quit; ods pdf close;
```

Appendix E: Measures for the Capacity-Building Evaluation

Coalition Assessment Tool

Your Name: **Date:**

This form is to be completed by coalition members in order to gauge the overall strength of the coalition and to identify areas that may need attention. For each characteristic please place a check mark under the scale value (from 1 to 5) that most appropriately indicates the strength and/or frequency of the characteristic. Please be candid in your responses, and keep in mind that it is OK (and even expected) that your coalition may not be strong in all areas.

Coalition Characteristics	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree	Don't know or NA
A. Vision, mission and goals:	**1**	**2**	**3**	**4**	**5**	**99**
1. Our coalition's vision, mission, and goals are clear and well-documented	☐	☐	☐	☐	☐	☐
2. Community residents are aware of our vision, mission, and goals	☐	☐	☐	☐	☐	☐
3. Our coalition periodically re-assesses and updates its mission and goals	☐	☐	☐	☐	☐	☐
4. We evaluate our coalition's activities in light of its mission and goals	☐	☐	☐	☐	☐	☐
5. Our coalition's vision, mission, and goals consider the needs and views of the community	☐	☐	☐	☐	☐	☐
6. Coalition members agree with the coalition's vision, mission, and goals	☐	☐	☐	☐	☐	☐
B. Coalition structure and membership:						
1. All of the necessary sectors of the community are represented	☐	☐	☐	☐	☐	☐
2. Our coalition has about the right number of active members	☐	☐	☐	☐	☐	☐
3. Coalition members' roles and responsibilities are well-defined	☐	☐	☐	☐	☐	☐
4. Our coalition has active committees or work groups	☐	☐	☐	☐	☐	☐
5. The persons needed to attend coalition meetings are usually there	☐	☐	☐	☐	☐	☐
6. Members communicate with one another as needed (not just at scheduled meetings)	☐	☐	☐	☐	☐	☐
7. Our coalition seeks to fill gaps in membership skills and expertise	☐	☐	☐	☐	☐	☐
C. Coalition leadership – Our coalition coordinator/director….						
1. Effectively promotes the mission and goals of the coalition	☐	☐	☐	☐	☐	☐
2. Encourages open dialog and expression of views among members	☐	☐	☐	☐	☐	☐
3. Utilizes the skills and experience of the members	☐	☐	☐	☐	☐	☐
4. Distributes responsibilities and tasks effectively	☐	☐	☐	☐	☐	☐
5. Is skillful at building positive relationships with community partners	☐	☐	☐	☐	☐	☐

6. Keeps the coalition focused on, and progressing towards, its goals	☐	☐	☐	☐	☐	☐
D. Outreach and communication:						
1. Our coalition keeps the community updated on its activities (e.g., through a newsletter, web site, etc.)	☐	☐	☐	☐	☐	☐
2. Our coalition goes to “where the residents are” to do outreach and to enhance its understanding of community issues	☐	☐	☐	☐	☐	☐
3. Our coalition engages youth to help inform its planning efforts	☐	☐	☐	☐	☐	☐
4. Our coalition works effectively with local media outlets	☐	☐	☐	☐	☐	☐
E. Coalition meetings and communications:						
1. Our coalition has a regular meeting cycle that members can count on	☐	☐	☐	☐	☐	☐
2. Agendas are sent to members in advance	☐	☐	☐	☐	☐	☐
3. Childcare is provided if needed	☐	☐	☐	☐	☐	☐
4. We accomplish meeting agendas in meetings that start and end on time	☐	☐	☐	☐	☐	☐
5. Meetings are held in centrally accessible, comfortable places and at convenient times for all members	☐	☐	☐	☐	☐	☐
6. Conflicts are resolved in an orderly and respectful manner	☐	☐	☐	☐	☐	☐
7. Meeting minutes are recorded	☐	☐	☐	☐	☐	☐

Coalition Characteristics - continued

	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree	Don’t know or NA
F. Opportunities for member growth and responsibility:						
1. New members receive an orientation and copies of relevant background materials	☐	☐	☐	☐	☐	☐
2. Our coalition makes a conscious effort to develop new leaders	☐	☐	☐	☐	☐	☐
3. Training is provided to members on relevant topics	☐	☐	☐	☐	☐	☐
4. We use a mentoring or “buddy system” to help less experienced members learn what is needed	☐	☐	☐	☐	☐	☐
5. Committees are given important tasks to do	☐	☐	☐	☐	☐	☐
6. Meetings are held as scheduled even if the coordinator cannot attend	☐	☐	☐	☐	☐	☐
G. Effectiveness in planning and implementation:						
1. Our coalition develops an annual work plan that lists goals and activities	☐	☐	☐	☐	☐	☐
2. Plans are based upon review and input from coalition members	☐	☐	☐	☐	☐	☐
3. Action plans and target dates are developed for each task or project	☐	☐	☐	☐	☐	☐
4. Coalition members are assigned specific responsibilities	☐	☐	☐	☐	☐	☐

5. Coalition activities and progress in completing tasks are monitored and reported to the membership	☐	☐	☐	☐	☐	☐
6. Our coalition gets things done rather just talk about them	☐	☐	☐	☐	☐	☐
H. Relationship with local government and other community leaders:						
1. Representatives from our coalition meet with local officials and community leaders	☐	☐	☐	☐	☐	☐
2. A coalition representative attends important community meetings	☐	☐	☐	☐	☐	☐
3. Our coalition coordinator understands the power structure and decision making process in community government	☐	☐	☐	☐	☐	☐
4. Our coalition participates in community-wide events	☐	☐	☐	☐	☐	☐
I. Partnerships with other organizations:						
1. Our coalition is knowledgeable about other community organizations and what they do	☐	☐	☐	☐	☐	☐
2. Our coalition collaborates with other community organizations	☐	☐	☐	☐	☐	☐
3. Our coalition utilizes information and resources from those organizations	☐	☐	☐	☐	☐	☐
4. Our coalition keeps abreast of issues affecting the community	☐	☐	☐	☐	☐	☐
5. Our coalition interacts and shares information with substance abuse prevention coalitions in other communities	☐	☐	☐	☐	☐	☐
J. Coalition members' sense of ownership and participation						
1. Our coalition builds social time for members into meetings and events	☐	☐	☐	☐	☐	☐
2. Members participate in social activities outside formal meetings	☐	☐	☐	☐	☐	☐
3. All members are treated equally and with respect	☐	☐	☐	☐	☐	☐
4. Members are asked about their interests and needs	☐	☐	☐	☐	☐	☐
5. Member contributions are recognized	☐	☐	☐	☐	☐	☐
6. Successes are celebrated	☐	☐	☐	☐	☐	☐
7. Members actively participate in the decision making process	☐	☐	☐	☐	☐	☐
8. Members feel free to speak their views without being criticized	☐	☐	☐	☐	☐	☐

Coalition Characteristics - continued	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree	Don't know or NA
K. Ability to collect, analyze, and use data						
1. Our coalition has members, or a consultant, with experience in collecting and analyzing data	☐	☐	☐	☐	☐	☐

2. Our coalition has members, or a consultant, with experience in conducting evaluations and preparing evaluation reports	☐	☐	☐	☐	☐	☐
3. Coalition members participate in reviewing data for planning and evaluation purposes	☐	☐	☐	☐	☐	☐
4. Our coalition has access to local data on substance abuse and consequences	☐	☐	☐	☐	☐	☐
L. Understanding of and commitment to environmental change strategies:						
1. Coalition members are familiar with concept of population-level change	☐	☐	☐	☐	☐	☐
2. Our coalition supports environmental change strategies (e.g., policy changes, regulation, enforcement, and advocacy) in addition to approaches targeting individuals	☐	☐	☐	☐	☐	☐
3. Our coalition is committed to working with the media	☐	☐	☐	☐	☐	☐
4. Our coalition has positive relationships with community partners needed to implement environmental strategies	☐	☐	☐	☐	☐	☐
M. Cultural competence:						
1. Our mission statement recognizes the importance of respecting cultural diversity (including racial/ethnic, gender, socioeconomic, and lifestyle)	☐	☐	☐	☐	☐	☐
2. Our coalition is engaged with diverse cultural groups and organizations	☐	☐	☐	☐	☐	☐
3. Our membership reflects the cultural makeup of the community	☐	☐	☐	☐	☐	☐
4. Our coalition reviews its activities and products to ensure they are culturally appropriate for the intended recipients	☐	☐	☐	☐	☐	☐
N. Funding and sustainability:						
1. Our coalition has received funding from multiple sources	☐	☐	☐	☐	☐	☐
2. Our coalition has the strong support of local government and other community organizations	☐	☐	☐	☐	☐	☐
3. Our coalition has the necessary office space and equipment to function effectively	☐	☐	☐	☐	☐	☐
4. Our coalition plans ahead for its long term sustainability in addition to its more immediate goals	☐	☐	☐	☐	☐	☐
5. Our coalition has members with experience in writing successful grant applications	☐	☐	☐	☐	☐	☐

Background information

O. Please place a check mark next to the response that best reflects your activities on the coalition.

1. Are you the coalition coordinator or director? ☐ Yes ☐ No

2. How many years have you been a member of the coalition?	☐ < 1	☐ 1-2	☐ 3-5	☐ > 5
3. How many coalition meetings did you attend in the past year (or since you started with the coalition if less than 1 year)?				
	☐ all or almost all of them	☐ about half of them	☐ a few of them	☐ hardly any o · none

Thank you!

Instrument adapted from the Vermont SPF-SIG Coalition Capacity Checklist

Community Prevention & Wellness Initiative (CPWI)
Coalition Progress Questionnaire 2016

Community: Date:

County Prevention Contact: Coalition Coordinator(s):

Present at visit: Year Coalition Formed: DBHR Staff:

This questionnaire is designed to facilitate a conversation with your Prevention System Manager about the current status of your coalition's implementation of CPWI and the support that you provide the coalition. Your coalition's effectiveness and success in the community is very important. Please answer the following questions honestly for a true assessment of your coalition's development and progress; how well CPWI is being implemented; and technical assistance and training needs. *For your convenience you may type into this document however, a typed response is not required for your on-site review.*

1. What skills and understanding in prevention theory do you have that help you meet the requirements of being a coalition coordinator? _____
2. What coalition development and communication skills do you and your coalition members have that help support the coalition's ability to continually improve its effectiveness, efficiency, and skill? _____
3. Provide some examples that demonstrate how key leaders and the community are informed about your coalition's mission and vision. _____
4. How do work groups or subcommittees function in your coalition? _____
5. Provide some examples that demonstrate how coalition meetings are action oriented. _____
6. Provide examples that demonstrate how the coalition is effectively communicating internally and with the community. How is communication culturally and linguistically appropriate? _____
7. What are ways that the coalition recruits new members? What role does the coalition play in recruitment? _____

8. How does the coalition provide effective equitable and respectful quality care and services? Please explain how the coalition is responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs? (CLAS Standards) _____

9. Now that you have completed a strategic plan, how will the coalition repeat the processes and approach used to assess the community needs and capacity when updating the strategic plan? (*This is the process used to identify the problem statement, risk factors, and local contributing factors for the Coalition Logic Model.)* _____

10. Discuss how the strategies outlined for each local contributing factor are sufficient to achieve the desired change in the local condition. _____

11. Please provide examples that demonstrate how your Action Plan timeline is realistic. _____

12. How are members and partners carrying out the strategies and activities identified in the action plan? _____

13. How does your coalition leverage funding/resources? _____

14. What sectors represented in the coalition membership are attending meetings regularly? _____

15. How does coalition staff support the members and volunteers as they carry out their plan? _____

16. What successful policy or systems change efforts has your coalition been instrumental in? _____

17. Discuss the ways the implemented strategies and activities reflect the culture of the community in which they are provided. _____
18. How does the coalition evaluate and monitor program effectiveness and outcomes? _____

Appendix F: Data Management Plan for CPWI

<u>Project name</u>
Community Prevention Wellness Initiative (CPWI) Evaluation

<u>Data sharing access and agreements</u>
We have a data sharing agreement with Washington State Department of Health (DOH) for HYS. We have received School District Profiles on Risk and Protection for Substance Abuse Prevention Planning from RDA, DSHS. We have received Minerva data from DBHR. We will receive Risk Score and Ranking data and PBPS data from DBHR. We got the remaining data files from publicly available sources.

<u>Access, storage, and backup</u>
We will digitally store data in Washington State Department of Human Development network server and computer, and only those researchers and lab coordinators listed in the data sharing agreement will be given access to the folder. Authorized personnel need a password to access the network server.

HYS data sharing agreement with the WA DOH prohibits storage of HYS data on mobile device (such as smart phones, tablets, laptops, notebook or netbook computers, personal media players), portable storage media (such as flash memory drives, portable hard disks), and cloud storage.

Data saved in the WSU network server is scheduled for automatic backups. Incremental backups occur every evening during the business week. Full backups occur once a week.

<u>Archiving and disposal</u>
We will retain individual HYS data files as well as the merged data file (HYS merged with other data files) for a maximum length of 3 years as per the terms of data sharing agreement. At the end of three years, we will destroy data files using the methods recommended by WA DOH.

<u>Data organization</u>
We will use hierarchical method of data organization, i.e. files will be organized in folder and subfolder. For each type of evaluation, the folder where files will be stored will have six subfolders:

1. Data – Data files will be stored here
2. Measures – Survey instruments, codebooks will be stored here
3. Output – Results generated from statistical software will be stored here
4. Syntax – Syntax used for statistical analyses will be stored here
5. Other – Any other file that does not belong to the above mentioned subfolders will be stored here
6. Reports – Report drafts will be stored here

Data documentation file

We will save data documentation file in an "Other" subfolder. This file will include the following information, when applicable:

1. Title: Name of the data file
2. Creator: Names, emails, and websites of organization or people who created data
3. Identifier: Number used to identify the data, even if it is just an internal project reference number
4. Dates: Key dates associated with the data, including project start and end dates, data modification date, data release date, and time period covered by the data
5. Subject: Keywords or phrases describing the subject or content of the data
6. Funders: Organizations or agencies who funded the research
7. Rights: Any known intellectual property rights held for the data
8. Language: Language(s) of the intellectual content of the resource
9. Location: Where the data relates to a physical location, record information about its spatial coverage
10. Methodology: How the data was generated. In case of secondary data, list the source of the data
11. Data quality issues: Does the data file have any issues related to data quality

(Data documentation information adapted from Documentation and Metadata provided by MIT libraries).

Version control

We will restrict data access and editing privileges to PIs and graduate research assistants. Only one person will work with a particular data file at any given time to avoid conflicting versions of the file. We will save a copy of the original version of data file in "Data/Master" subfolder. When naming files/folder, we will use v01, v02 and so on for major version changes, and v0101, v0102 and so on for minor changes.

File naming convention

We will adhere to the following guidelines

a. Be clear, concise, consistent, correct, and conformant
b. Provide context (content-specific or descriptive information)
c. Keep file names short but meaningful
d. Avoid using generic file names that may conflict when moved from one location to another location
e. Use underscore to differentiate between words (avoid spaces in file names)
f. Do not use capital letters in file names unless using it for proper nouns or acronyms (capital letters in file names affect ordering)

(Naming convention information adapted from Research Data Management provided by MIT libraries).

Environmental Factors and Plan

9. Statutory Criterion for MHBG - Required for MHBG

Narrative Question

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.

Please respond to the following items

Criterion 1

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occuring 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 cover a wide variety of services in support of the individuals in their catchment area to live in their communities. At the lower service level there is brief intervention. Some examples of the services provided on a community level include crisis services, outpatient mental health counseling, group and family treatment, case management, medication management, and medication monitoring. There is also higher level of outpatient resources such as intensive services for youth and families, respite services, and the program of assertive community treatment (PACT). 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	◉ Yes ○ No
b)	Mental Health	◉ Yes ○ No
c)	Rehabilitation services	◉ Yes ○ No
d)	Employment services	◉ Yes ○ No
e)	Housing services	◉ Yes ○ No
f)	Educational Services	◉ Yes ○ No
g)	Substance misuse prevention and SUD treatment services	◉ Yes ○ No
h)	Medical and dental services	◉ Yes ○ No
i)	Support services	◉ Yes ○ No
j)	Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)	◉ Yes ○ No
k)	Services for persons with co-occuring M/SUDs	◉ Yes ○ No

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. However, 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 activities 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: Mental Health System Data Epidemiology
Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

Criterion 2

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)
1.Adults with SMI	103,208	N/A
2.Children with SED	40,319	N/A

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 a 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 in order for children to receive care for their multiple needs. Does your state integrate the following services into a comprehensive system of care?

a)	Social Services	(●) Yes ( ) No
b)	Educational services, including services provided under IDE	(●) Yes ( ) No
c)	Juvenile justice services	(●) Yes ( ) No
d)	Substance misuse preventiion and SUD treatment services	(●) Yes ( ) No
e)	Health and mental health services	(●) Yes ( ) No
f)	Establishes defined geographic area for the provision of services of such system	(●) Yes ( ) No

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults

Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.

Criterion 4

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 is 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 adult population.

In regard to 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: Management Systems

States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

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:

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.

Environmental Factors and Plan

10. Substance Use Disorder Treatment - Required SABG

Narrative Question

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

Criterion 1

Improving access to treatment services

1. Does your state provide:

a) A full continuum of services

		Answer
i)	Screening	◉ Yes ○ No
ii)	Education	◉ Yes ○ No
iii)	Brief Intervention	○ Yes ◉ No
iv)	Assessment	◉ Yes ○ No
v)	Detox (inpatient/social)	◉ Yes ○ No
vi)	Outpatient	◉ Yes ○ No
vii)	Intensive Outpatient	◉ Yes ○ No
viii)	Inpatient/Residential	◉ Yes ○ No
ix)	Aftercare; Recovery support	◉ Yes ○ No

b) Services for special populations:

	Answer
Targeted services for veterans?	○ Yes ◉ No
Adolescents?	◉ Yes ○ No
Other Adults?	○ Yes ◉ No
Medication-Assisted Treatment (MAT)?	◉ Yes ○ No

Criterion 2

Criterion 3

1. Does your state meet the performance requirement to establish and/or maintain new programs or expand programs to ensure treatment availability? ◉ Yes ○ No

2. Does your state make prenatal care available to PWWDC receiving services, either directly or through an arrangement with public or private nonprofit entities? ◉ Yes ○ No

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? ◉ Yes ○ No

4. Does your state have an arrangement for ensuring the provision of required supportive services? ◉ Yes ○ No

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

- **a)** Open assessment and intake scheduling ◉ Yes ○ No
- **b)** Establishment of an electronic system to identify available treatment slots ◉ Yes ○ No
- **c)** Expanded community network for supportive services and healthcare ◉ Yes ○ No
- **d)** Inclusion of recovery support services ◉ Yes ○ No
- **e)** Health navigators to assist clients with community linkages ◉ Yes ○ No
- **f)** Expanded capability for family services, relationship restoration, and custody issues? ◉ Yes ○ No
- **g)** Providing employment assistance ◉ Yes ○ No
- **h)** Providing transportation to and from services ◉ Yes ○ No
- **i)** Educational assistance ○ Yes ◉ 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.

Criterion 4,5&6

Persons Who Inject Drugs (PWID)

1. Does your state fulfill the:

a)	90 percent capacity reporting requirement	(•) Yes ( ) No
b)	14-120 day performance requirement with provision of interim services	( ) Yes ( ) No
c)	Outreach activities	(•) Yes ( ) No
d)	Syringe services programs, if applicable	(•) Yes ( ) No
e)	Monitoring requirements as outlined in the authorizing statute and implementing regulation	(•) Yes ( ) No

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

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

3. States are required to monitor program compliance related to activites 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, the Behavioral Health Organizations (BHO), and the Fully Integrated Managed Care (FIMC) Organizations. The BHOs and FIMC 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 BHOs and the FIMC 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 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 BHOs and FIMC 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 BHOs and FIMC 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? (•) Yes ( ) No

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

a)	Business agreement/MOU with primary healthcare providers	(•) Yes ( ) No
b)	Cooperative agreement/MOU with public health entity for testing and treatment	(•) Yes ( ) No
c)	Established co-located SUD professionals within FQHCs	( ) Yes (•) 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 on the basis of 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 currently 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 the service delivery? ○ Yes ◉ No

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

   a) Establishment of EIS-HIV service hubs in rural areas ○ Yes ◉ No

   b) Establishment or expansion of tele-health and social media support services ◉ Yes ○ No

   c) Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS ○ Yes ◉ 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.CÂ§ 300x-31(a)(1)F)? ◉ Yes ○ No

2. Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program? ○ Yes ◉ No

3. Do any of the programs use SABG funds to support elements of a Syringe Services Program? ○ Yes ◉ No

   If yes, plese provide a brief description of the elements and the arrangement

Criterion 8,9&10

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 ( ) No

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

- **a)** Workforce development efforts to expand service access — (●) Yes ( ) No
- **b)** Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services — (●) Yes ( ) No
- **c)** Establish a peer recovery support network to assist in filling the gaps — (●) Yes ( ) No
- **d)** Incorporate input from special populations (military families, service memebers, veterans, tribal entities, older adults, sexual and gender minorities) — ( ) Yes (●) No
- **e)** Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, i.e. primary healthcare, public health, VA, community organizations — ( ) Yes (●) No
- **f)** Explore expansion of services for:
  - **i)** MAT — (●) Yes ( ) No
  - **ii)** Tele-Health — (●) Yes ( ) No
  - **iii)** Social Media Outreach — (●) Yes ( ) No

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 ( ) No

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 ( ) No
- **b)** Establish a program to provide trauma-informed care — (●) Yes ( ) No
- **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 systems, adult criminal justice systems, and education — (●) Yes ( ) No

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 ( ) No

2. Does your state provide any of the following:

- **a)** Notice to Program Beneficiaries — ( ) Yes (●) No
- **b)** An organized referral system to identify alternative providers? — (●) Yes ( ) No
- **c)** A system to maintain a list of referrals made by religious organizations? — ( ) Yes (●) 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 ( ) No

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

- **a)** Review and update of screening and assessment instruments — (●) Yes ( ) No
- **b)** Review of current levels of care to determine changes or additions — (●) Yes ( ) No
- **c)** Identify workforce needs to expand service capabilities — (●) Yes ( ) No

d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background — ◉ Yes ○ No

Patient Records

1. Does your state have an agreement to ensure the protection of client records? — ◉ Yes ○ No

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

a) Training staff and community partners on confidentiality requirements — ◉ Yes ○ No

b) Training on responding to requests asking for acknowledgement of the presence of clients — ◉ Yes ○ No

c) Updating written procedures which regulate and control access to records — ◉ Yes ○ No

d) Review and update of the procedure by which clients are notified of the confidentiality of their records including the exceptions for disclosure: — ◉ Yes ○ No

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? — ◉ Yes ○ No

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.

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 FFY21 will have 33 substance abuse providers to be reviewed and 21 mental health providers to be reviewed (Reviews are happening during August 2021 and September 2021) the state expects to review the same number of providers in FFY22 and FFY23.

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

a) Development of a quality improvement plan — ◉ Yes ○ No

b) Establishment of policies and procedures related to independent peer review — ◉ Yes ○ No

c) Development of long-term planning for service revision and expansion to meet the needs of specific populations — ◉ Yes ○ No

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? — ○ Yes ◉ No

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&11

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 ○ No
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 ○ No
   - b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing ◉ Yes ○ No

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 ○ No
   - b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services ◉ Yes ○ No
   - c) Performance-based accountability: ◉ Yes ○ No
   - d) Data collection and reporting requirements ◉ Yes ○ No
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 ○ No
   - b) Addition of training sessions designed to increase employee understanding of recovery support services ◉ Yes ○ No
   - c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services ◉ Yes ○ No
   - 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 ○ No
3. Has your state utilized the Regional Prevention, Treatment and/or Mental Health Training and Technical Assistance Centers (TTCs)?
   - a) Prevention TTC? ◉ Yes ○ No
   - b) Mental Health TTC? ○ Yes ◉ No
   - c) Addiction TTC? ◉ Yes ○ No
   - d) State Targeted Response TTC? ○ Yes ◉ 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 ○ Yes ◉ No
2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus:
   - a) Tuberculosis ○ Yes ◉ No
   - b) Early Intervention Services Regarding HIV ○ Yes ◉ No
3. Additional Agreements
   - a) Improvement of Process for Appropriate Referrals for Treatment ○ Yes ◉ No
   - b) Professional Development ○ Yes ◉ No

c) Coordination of Various Activities and Services ○ Yes ◉ 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

Footnotes:

Environmental Factors and Plan

11. Quality Improvement Plan- Requested

Narrative Question

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

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2020-FFY 2021? ○ Yes ○ No

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

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

12. Trauma - Requested

Narrative Question

Trauma [57] is a widespread, harmful, and costly public health problem. It occurs because of violence, abuse, neglect, loss, disaster, war and other emotionally harmful and/or life threatening experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective M/SUD service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in M/SUD services. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated M/SUD problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions. Schools are now recognizing that the impact of exposure to trauma and violence among their students makes it difficult to learn and meet academic goals. Communities and neighborhoods experience trauma and violence. For some these are rare events and for others these are daily events that children and families are forced to live with. These children and families remain especially vulnerable to trauma-related problems, often are in resource poor areas, and rarely seek or receive M/SUD care. States should work with these communities to identify interventions that best meet the needs of these residents.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink doing ?business as usual.? These public institutions and service settings are increasingly adopting a trauma-informed approach. A trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to these appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma[58] paper.

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

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

1. Does the state have a plan or policy for M/SUD providers that guide how they will address individuals with trauma-related issues? ○ Yes ○ No
2. Does the state provide information on trauma-specific assessment tools and interventions for M/SUD providers? ○ Yes ○ No
3. Does the state have a plan to build the capacity of M/SUD providers and organizations to implement a trauma-informed approach to care? ○ Yes ○ No
4. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations? ○ Yes ○ No
5. Does the state have any activities related to this section that you would like to highlight.

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

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13. Criminal and Juvenile Justice - Requested

Narrative Question

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one-third meet criteria for having co-occurring mental and substance use problems. Youth in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.[59]

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.[60]
A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with M/SUD from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment Medicaid and/or the Health Insurance Marketplace; loss of eligibility for Medicaid resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

The MHBG and SABG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

[59] Journal of Research in Crime and Delinquency: *: Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice.*Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Ren?e L. Binder. **OJJDP Model Programs Guide**
[60] **http://csgjusticecenter.org/mental-health/**

Please respond to the following items

1. Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to M/SUD services? ○ Yes ○ No
2. Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, M/SUD provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms? ○ Yes ○ No
3. Does the state provide cross-trainings for M/SUD providers and criminal/juvenile justice personnel to increase capacity for working with individuals with M/SUD issues involved in the justice system? ○ Yes ○ No
4. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address M/SUD and other essential domains such as employment, education, and finances? ○ Yes ○ No
5. Does the state have any activities related to this section that you would like to highlight?

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

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14. Medication Assisted Treatment - Requested (SABG only)

Narrative Question

There is a voluminous literature on the efficacy of medication-assisted treatment (MAT); the use of FDA approved medication; counseling; behavioral therapy; and social support services, in the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for MAT for SUDs is described in SAMHSA TIPs 40[1], 43[2], 45[3], 49 [4], and 63[5].

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to use MAT or have collaborative relationships with other providers that can provide the appropriate MAT services clinically needed.

Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs.

In addition, SAMHSA also encourages states to require the use of MAT for substance use disorders for opioid use, alcohol use, and tobacco use disorders where clinically appropriate.

SAMHSA is asking for input from states to inform SAMHSA's activities.

TIP 40 - https://www.ncbi.nlm.nih.gov/books/NBK64245/ [ncbi.nlm.nih.gov]

TIP 43 - https://www.ncbi.nlm.nih.gov/books/NBK64164/ [ncbi.nlm.nih.gov]

TIP 45 - https://store.samhsa.gov/sites/default/files/d7/priv/sma15-4131.pdf [store.samhsa.gov]

TIP 49 - https://store.samhsa.gov/sites/default/files/d7/priv/sma13-4380.pdf [store.samhsa.gov]

TIP 63 - https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-02-01-006_508.pdf [store.samhsa.gov]

Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding MAT for substance use disorders? ○ Yes ○ No

2. Has the state implemented a plan to educate and raise awareness of the use of MAT within special target audiences, particularly pregnant women? ○ Yes ○ No

3. Does the state purchase any of the following medication with block grant funds? ○ Yes ○ No

- **a)** ☐ Methadone
- **b)** ☐ Buprenophine, Buprenorphine/naloxone
- **c)** ☐ Disulfiram
- **d)** ☐ Acamprosate
- **e)** ☐ Naltrexone (oral, IM)
- **f)** ☐ Naloxone

4. Does the state have an implemented education or quality assurance program to assure that evidence-based MAT with the use of FDA-approved medications for treatment of substance abuse use disorders are used appropriately*? ○ Yes ○ No

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

**Appropriate use is defined as use of medication for the treatment of a substance use disorder, combining psychological treatments with approved medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, and advocacy with state payers.*

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15. Crisis Services - Required for MHBG

Narrative Question

In the on-going development of efforts to build an robust system of evidence-based care for persons diagnosed with SMI, SED and SUD and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from M/SUD crises. SAMHSA has recently released a publication, Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies that states may find helpful.[61] SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with M/SUD conditions and their families. According to SAMHSA's publication, **Practice Guidelines: Core Elements for Responding to Mental Health Crises**[62],

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

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

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[61] **http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848**

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

Please check those that are used in your state:

1. Crisis Prevention and Early Intervention

- **a)** ☑ Wellness Recovery Action Plan (WRAP) Crisis Planning
- **b)** ☑ Psychiatric Advance Directives
- **c)** ☑ Family Engagement
- **d)** ☑ Safety Planning
- **e)** ☑ Peer-Operated Warm Lines
- **f)** ☐ Peer-Run Crisis Respite Programs
- **g)** ☑ Suicide Prevention

2. Crisis Intervention/Stabilization

- **a)** ☑ Assessment/Triage (Living Room Model)
- **b)** ☐ Open Dialogue
- **c)** ☑ Crisis Residential/Respite
- **d)** ☑ Crisis Intervention Team/Law Enforcement
- **e)** ☑ Mobile Crisis Outreach
- **f)** ☑ Collaboration with Hospital Emergency Departments and Urgent Care Systems

3. Post Crisis Intervention/Support

- **a)** ☑ Peer Support/Peer Bridgers
- **b)** ☑ Follow-up Outreach and Support
- **c)** ☑ Family-to-Family Engagement
- **d)** ☑ Connection to care coordination and follow-up clinical care for individuals in crisis
- **e)** ☑ Follow-up crisis engagement with families and involved community members

f) ☑ Recovery community coaches/peer recovery coaches

g) ☑ Recovery community organization

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

Washington will be substantially expanding mobile crisis outreach services including child/youth teams on a statewide basis. We have peer respite programs in development, but they have started providing services yet.

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

None at this time.

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16. Recovery - Required

Narrative Question

The implementation of recovery supports and services are imperative for providing 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 guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. Because mental and substance use disorders are chronic conditions, systems and services are necessary to facilitate the initiation, stabilization, and management of long-term recovery.

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 to the greatest extent possible, 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.

Lastly, 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.

In addition to the Foundational Community Supports, the Housing and Recovery through Peer Services (HARPS) is available to individuals with serious mental illness at risk of exiting or 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 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 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.

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 deliver 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 May, 2021, we have 342 Oxford Houses and 2977 Beds available on a daily basis.
• Total Women's Houses are 105 and 46 of those Houses are for Women with Children.
• Total of Men's Houses are 237 and 20 of those Houses are for Men with Children.
• In the 342 Oxford Houses there are 276 houses and with 929 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.

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 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

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.

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17. Community Living and the Implementation of Olmstead - Requested

Narrative Question

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

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

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

Please respond to the following items

1. Does the state's Olmstead plan include :

Housing services provided.	○ Yes ○ No
Home and community based services.	○ Yes ○ No
Peer support services.	○ Yes ○ No
Employment services.	○ Yes ○ No

2. Does the state have a plan to transition individuals from hospital to community settings? ○ Yes ○ No

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

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18. Children and Adolescents M/SUD Services - Required MHBG, Requested SABG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG 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.[63]. 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.[64]. For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death.[65].

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.[66]. 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.[67].

According to data from the 2015 Report to Congress[68] 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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[63]Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

[64]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.

[65]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.

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

[67]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**

[68] **http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf**

Please respond to the following items:

1. Does the state utilize a system of care approach to support:

a) The recovery and resilience of children and youth with SED? ◉ Yes ○ No

b) The recovery and resilience of children and youth with SUD? ◉ Yes ○ No

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 ○ No

b) Juvenile justice? ◉ Yes ○ No

c) Education? ◉ Yes ○ No

3. Does the state monitor its progress and effectiveness, around:

a) Service utilization? ◉ Yes ○ No

b) Costs? ◉ Yes ○ No

c) Outcomes for children and youth services? ◉ Yes ○ No

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 ○ No

b) Mental health treatment and recovery services for children/adolescents and their families? ◉ Yes ○ No

5. Does the state have plans for transitioning children and youth receiving services:

a) to the adult M/SUD system? ◉ Yes ○ No

b) for youth in foster care? ◉ Yes ○ No

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 Children's. Behavioral Health Governance Structure, in informing and providing oversight for high-level policymaking, program planning, decision-making, and serves as a mechanism for ensuring that local community input and the voice of lived experience is present, participating in, and informing legislative workgroups. In alignment with the Children's Behavioral Health Principles, the Statewide and Regional FYSPRT recommends strategies to provide behavioral health services and supports for children and youth as well as monitor and 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 driven and youth guided, 2) Cultural and linguistic appropriate services and 3) community-based services and support the goals of the Washington State system of care:

1) Infuse system of care principles 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 children's behavioral health principles.
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, 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 no 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 indicate areas of technical assistance needed related to this section.

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Footnotes:

Environmental Factors and Plan

19. Suicide Prevention - Required for MHBG

Narrative Question

Suicide is a major public health concern, it is the 10th leading cause of death overall, with over 40,000 people dying by suicide each year 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 items:

1. Have you updated your state's suicide prevention plan in the last 2 years? ○ Yes ◉ No

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. All CBO's with mental health promotion and suicide prevention funding must provide Youth Mental Health First Aid (YMHFA) and a Community Awareness Event/Activity addressing mental health promotion and/or suicide prevention, which can include stigma reduction, signs and symptoms/warning signs, asking the question (Are you having thoughts of suicide) and community resources including crisis lines and treatment facilities. In addition, CBOs focused on suicide prevention may include the following programs or implement an approved innovative program or strategy: Coping and Support Training (CAST), Good Behavior Game, Sources of Strength, and Question Persuade Refer (QPR).
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.
Emergency Response Suicide Prevention Grant: The Health Care Authority (HCA) received SAMHSA funds to work with the University of Washington Harborview Medical Center (UWHMC) Behavioral Health Institute (BHI) to develop a support plan for people who have a suicide crisis. The plan includes technology and peer navigators for adults over the age of 25, including victims of domestic violence.
The technology portion of the plan, Jaspr Health, helps individuals and their providers to use the recommended evidence-based practices for suicide crisis care. The app delivers supports the use of suicide prevention best practices to for people while they are in the hospital and after they return home. Peer navigators provide caring emotional support and assistance connecting with behavioral health services, recovery supports, and develop and use suicide recovery plans.
The grant will also fund free training for up to 6,000 behavioral health providers. Training will include:
• Assessment of suicide risk and protective factors
• Best practice interventions to ensure safety (removing the means for intent)
• Treatment of individuals
• Follow-up to ensure continuity of care

3. Have you incorporated any strategies supportive of Zero Suicide? ◉ Yes ○ No

4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments? ○ Yes ◉ No

5. Have you begun any targeted or statewide initiatives since the FFY 2020-FFY 2021 plan was submitted? ◉ Yes ○ No

If so, please describe the population targeted.

Emergency Response Suicide Prevention Grant: Adults over the age of 25, including victims of domestic violence.

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

None at this time.

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Footnotes:

Environmental Factors and Plan

20. Support of State Partners - Required for MHBG

Narrative Question

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

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

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period? ◉ Yes ○ No

2. Has your state identified the need to develop new partnerships that you did not have in place? ◉ Yes ○ No

If yes, with whom?

Accountable Communities of Health (ACHs), FCS and Opiate work partners.

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

None at this time.

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Footnotes:

Environmental Factors and Plan

21. State Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application- Required for MHBG

Narrative Question

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 SABG, 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.**[69]

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.

[69] **https://www.samhsa.gov/sites/default/files/manual-planning-council-best-practices-2014.pdf**

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? Please attach supporting documentation (meeting minutes, letters of support, etc.) using the upload option at the bottom of this page.

a) What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment and recovery services?

Draft versions of the FY2022-23 Block Grant application were submitted to BHAC for review prior to their July meeting before incorporating commentary from a tribal roundtable in July. The grant application was discussed at the meeting on July 7th and the council members were given additional time to review further. Feedback was reviewed and considered following the meeting.

b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work? ◉ Yes ○ No

2. Is the membership representative of the service area population (e.g. ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)? ◉ Yes ○ No

3. 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 64 percent 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. The council also includes many partners and stakeholders from other state agencies including the Health Care Authority, Children's Administration, Long Term Care, Developmental Disabilities, Juvenile Rehabilitation, Department of Health, 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.

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

None at this time.

Additionally, please complete the Advisory Council Members and Advisory Council Composition by Member Type forms.[70]

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

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Footnotes:

Washington State Health Care Authority

July 7th, 2021 –9:30 am – 3:15 pm
Microsoft Teams

Behavioral Health Advisory Council

Attendees:					
☒	Ahney King	☐	Keri Waterland	☒	Ruth Leonard
☐	Beth Dannhardt	☐	Kimberly Conner	☐	Sandra Mena-Tyree
☐	Brian Briggs	☐	~~Kristina Sawyckyj~~	☐	Sharon McKellery
☐	Carolyn Cox	☐	Lateish De Lay	☐	Shelby M Satko
☐	~~Dennis Swennumson~~	☐	Maricia Mongrain-Finkas	☐	Shelli Young
☐	Dixie Grunenfelder	☐	Mari Huesman	☐	Steve Kutz
☒	Haley Tibbits	☐	Maria Nunez	☐	Stu Parker
☐	Jeff Spring	☒	Mary O'Brian	☐	Susan Kydd
☒	Jenni Olmstead	☐	Melodie Pazolt	☐	Taku Mineshita
☐	Jimsy Chorath	☐	Michael Langer	☒	Tana Russell
☐	John Tuttle	☐	Michael Reading	☒	Vanessa Lewis
☐	~~Jorden Rosa~~	☐	Nelson Rascon	☒	Janet Cornell
☒	Josh Wallace	☒	Pamala Sacks-Lawler	☒	Louise Neito
☒	Julirae Castleton	☐	Paul Neilson	☐	
☐	Karen Huber	☐	Payton Bordley	☐	
☒	Katie Murkovich	☒	Richard Brown	☐	
☐	Kelly Boston	☒	Richelle Madigan	☐	
☐	**Facilitator**: Tori McDermott Hale	☐	**Guest:**	☐	
☐	**Guest:** Senator Judy Warnick	☐	**Guest:**	☐	**Minutes:** Tori McDermott Hale
☐	**Guest:**	☐	**Guest:**	☐	**Guest:**

Main Outcome: *The Behavioral Health Advisory Council mission is to advise and educate the Division of Behavioral Health and Recovery, for planning and implementation of effective, integrated behavioral health services by promoting individual choice, prevention, and recovery in Washington State*

July 7th, 2021 – 9:30 am – 3:15 pm
Microsoft Teams

Behavioral Health Advisory Council

No	Agenda Items	Time	Lead	Summary Meeting Notes
1.	**CALL TO ORDER** - **Welcome and attendance** - **Introduction of new members** - **Approval of May Minutes**	9:30 am	Josh Wallace	
2.	**Section Update: Adult SUD**	10:00 am	Edward Michael	
3.	**FY 22-23 Block Grant Application**	11:00 am	Janet Cornell	
4.	**Break**	12:00 pm	All	
5.	**Membership Committee – New Members**	12:30 pm	Vanessa Lewis	
6.	**Peer Review Team**	12:45 pm	Josh Wallace	
7.	**Directors Update**	1:00 pm	Keri Waterland	
8.	**Guest Legislature – Senator Judy Warnick**	2:00 pm	Richelle Madigan & Senator Judy Warnick	
9.	**Action Item Recap** **September Agenda Items** **Ajourn**	3:00 pm 3:15 pm	All	

Washington State Health Care Authority

July 7th, 2021 –9:30 am – 3:15 pm
Microsoft Teams

Behavioral Health Advisory Council

Attendees:					
☒	Ahney King	☐	Keri Waterland	☒	Ruth Leonard
☐	Beth Dannhardt	☐	Kimberly Conner	☐	Sandra Mena-Tyree
☐	Brian Briggs	☐	~~Kristina Sawyckyj~~	☐	Sharon McKellery
☐	Carolyn Cox	☐	Lateish De Lay	☐	Shelby M Satko
☐	~~Dennis Swennumson~~	☐	Maricia Mongrain-Finkas	☐	Shelli Young
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☒	Haley Tibbits	☐	Maria Nunez	☐	Stu Parker
☐	Jeff Spring	☒	Mary O'Brian	☐	Susan Kydd
☒	Jenni Olmstead	☐	Melodie Pazolt	☐	Taku Mineshita
☐	Jimsy Chorath	☐	Michael Langer	☒	Tana Russell
☐	John Tuttle	☐	Michael Reading	☒	Vanessa Lewis
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☒	Josh Wallace	☒	Pamala Sacks-Lawler	☒	Louise Neito
☒	Julirae Castleton	☐	Paul Neilson	☐	
☐	Karen Huber	☐	Payton Bordley	☐	
☒	Katie Murkovich	☒	Richard Brown	☐	
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☐	**Facilitator**: Tori McDermott Hale	☐	**Guest:**	☐	
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☐	**Guest:**	☐	**Guest:**	☐	**Guest:**

Main Outcome: *The Behavioral Health Advisory Council mission is to advise and educate the Division of Behavioral Health and Recovery, for planning and implementation of effective, integrated behavioral health services by promoting individual choice, prevention, and recovery in Washington State*

Behavioral Health Advisory Council

No	Agenda Items	Lead	Summary Meeting Notes
1.	**CALL TO ORDER** - **Welcome and attendance** - **Introduction of new members** - **Approval of May Minutes**	Josh Wallace	• Meeting started at 9:35 am. • May minutes were approved by Quorum
2.	**Section Update: Adult SUD**	Edward Michael	• Please review the Adult SUD presentation.
3.	**FY 22-23 Block Grant Application**	Janet Cornell	• Priorities below – Janet Cornell reviewed the Block Grant Priorities with BHAC. • A member of BHAC, asked calrifing questions about the number of individuals served through the supportive housing work. Janet shared the FCS Admin Reports with the members after the meeting. • A request to send additional Application recommendations to Janet Cornell was made at the end of the presentation. **Planning Tables - DRAFT** **Table 1 Priority Areas and Annual Performance Indicators** *Priority #: 1* **Priority Area:** Reduce Underage and Young Adult Substance Use/Misuse **Priority Type:** SAP **Population(s):** PP, Other (Adolescents w/SUD and/or MH, Rural, Asian, Tribal communities, Native Hawaiian/Other Pacific Islanders, Underserved Racial and Ethnic Minorities) **Goal of the priority area:** Decrease the use and misuse of alcohol, marijuana, tobacco, opioids or other prescription drugs, and the use of any other drugs in the last 30 days.

			Objective: • Decrease the percentage of 10th graders who report using alcohol in the last 30 days (HYS 2018: 18.5%; Target 2023: 18%). • Prevent the increase in the percentage of 10th graders who report using marijuana in the last 30 days (HYS 2018: 17.9%, Target 2023: 15.3%). • Decrease the percentage of 10th graders who report using tobacco products in the last 30 days (HYS 2018 Tobacco, any form except vape: 7.6%, Target 2023: 9.2%; HYS 2018 Tobacco – vape: 21.2%, Target 2023: 11.4%). • Decrease the percentage of 10th graders who report misusing/abusing painkillers in the past 30 days (HYS 2018: 6.8%, Target 2023: 4.0%). • Decrease the percentage of young adults who report using marijuana (HYS 2018: 48.5%; Target 2023: 43.7%) • Decrease the percentage of young adults who report using alcohol in the last 30 days (HYS 2018: 61.1%; Target 2023: 55%) **Strategies to attain the objective:** • Implement performance-based contracting with each prevention contractor. • Adapt programs to address the unique needs of each tribe. • 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). • Provide statewide Workforce Development Training to build capacity for service delivery. • Develop best practices strategies to target underserved populations such as Black, Indigenous, and People of Color and Tribal groups. **Annual Performance Indicators to Measure Goal Success** **Indicator #:** 1 **Indicator:** Reduce substance use/misuse **Baseline Measurement:** 13,592 unduplicated direct services provided during SFY 2020 (July 1, 2019 – June 30, 2020) **First-year target/outcome measurement:** Maintain or increase number of prevention programs and participants

			compared to the SFY20 baseline (July 1, 2019 – June 30, 2020) of 13,592 unduplicated direct services **Second-year target/outcome measurement:** Maintain or increased number of prevention programs and participants compared to the SFY20 baseline (July 1, 2019 – June 30, 2020) of 13,592 unduplicated direct services **Data Source:** Washington's Management Information Service (SUD Prevention and MH Promotion Online Reporting System): used to report SABG performance indicators. Washington State Healthy Youth Survey (HYS): used to report 30 day use biannually. Washington State Young Adult Health Survey (YAHS): used to report young adult (Ages 18-25) substance use/misuse. Minerva **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. **Data issues/caveats that affect outcome measures:** Data integrity is 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. *Priority #: 2* **Priority Area:** Increase the number of youth receiving outpatient substance use disorder treatment **Priority Type:** SAT **Population(s):** PWWDC, PWID, Other (Adolescents w/SA and/or MH, LGBTQ, Rural, Criminal/Juvenile Justice, Children/Youth at Risk for BH Disorder, Youth Experiencing

Homeless, Asian, tribal communities, Native Hawaiian/Other Pacific Islanders, Underserved Racial and Ethnic Minorities)

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

Objective:
• Require Behavioral Health Organizations (BHOs) 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 SUD 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 BHOs and MCOs to ensure focus and oversight of provider network.

Annual Performance Indicators to Measure Goal Success

Indicator #: 1

Indicator: Increase youth outpatient SUD treatment services

Baseline Measurement: SFY20 (July 1, 2019 – June 30, 2020): 1,695 youth received SUD outpatient treatment services

First-year target/outcome measurement: Increase the number of youth receiving SUD outpatient treatment services in SFY22 to??

Second-year target/outcome measurement: Increase the number of youth receiving SUD outpatient treatment services in SFY23 to??

NOTE: Our ability to improve our baseline was significantly impacted by COVID-19, we may continue to use the same targets for the SFY 2022-2023.

	SFY 2020
Target/Outcome Measure	3,584
Results	1,695

Data Source:
The number of youth receiving SUD outpatient services is tracked using the Behavioral Health Administration (BHA) 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 2016 data is an unduplicated count of youth (persons under 18 years of age) served in publicly funded SUD outpatient treatment between January 1, 2017, and December 31, 2018.

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. Indian Health Care Providers have to enter data into multiple systems which can be burdensome.

Priority #: 3

Priority Area: Increase the number of SUD Certified Peers

Priority Type: SAT

Population(s): PWWDC, PWID, TB, Other (Adolescents w/SA and/or MH, Students in College, LGBTQ, Children/Youth at Risk for BH Disorder, Homeless, Asian, Tribal communities, Native Hawaiian/Other Pacific Islanders, Underserved Racial and Ethnic Minorities)

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:

• BHA/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

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: SUD peer support program

Baseline Measurement: From July 1, 2019 – June 30, 2020 total number of SUD trained peers was 802

First-year target/outcome measurement: Peer support program in SFY22 that would train 280 peers **Second-year target/outcome measurement:** Peer support program in SFY23 that would train 350 peers

The number of individuals trained through the SUD Peer Support Program increased during the SFY 2020 due to virtual training options available.

	SFY 2019
Target/Outcome Measure	200
Results	219

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 #: 4 **Priority Area:** Increase outpatient mental health services for youth with SED **Priority Type:** MHS **Population(s):** SED **Goal of the priority area:** The primary goal is to increase community based behavioral health services to youth who are diagnosed with SED. **Objective:** • Require the Behavioral Health Organizations (BHOs) and I/T/U to improve and enhance available behavioral health services to youth. **Strategies to attain the objective:** • Require BHOs 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 MH services to youth with SED **Baseline Measurement:** SFY20: 68,113 youth with SED received services **First-year target/outcome measurement:** Maintain the number of youth with SED receiving outpatient services to at least 40,820 in SFY22 (we anticipate a decrease in numbers, bringing us closer to our normal baseline as Covid decreases) **Second-year target/outcome measurement:** Maintain the number of youth with SED receiving outpatient services to at least 41,320 in SFY23 SFY22 (we anticipate a decrease in

numbers, bringing us closer to our normal baseline as Covid decreases)

	SFY 2020
Target/Outcome Measure	40,820
Results	68,113

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

Description of Data:
Fiscal Year 2018 is an unduplicated count of youth with SED who under the age of 18 served in publicly funded outpatient mental health programs from July 1, 2017 through June 30, 2018.

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

Priority #: 5

Priority Area: Increase capacity for early identification and intervention for individuals experiencing First Episode Psychosis.

Priority Type: MHS

Population(s): 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 FEP

Strategies to attain the objective:
• Provide funding to increase the number of agencies who serve youth with FEP.

• Increase available MH community based behavioral health services for youth diagnosed with FEP.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase outpatient MH capacity for youth with FEP.

Baseline Measurement: SFY20: 11 FEP Programs, serving a total of 325 youth

First-year target/outcome measurement: FY22 (July 1, 2021 – June 30, 2022) Increase the number of coordinated specialty care sites from 11 to 12 serving an additional 25 youth statewide (total of 350 youth served).

Second-year target/outcome measurement: FY23 (July 1, 2022 – June 30, 2023) Maintain the 12 coordinated specialty care sites, serving an additional 75 youth statewide (total of 425 youth served).

Results:

	SFY 2020
Target/Outcome Measure	5-9 Sites, 100 addition
Results	11 sites, 325 youth ser

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

Priority #: 6

Priority Area: Increase the number of adults with SMI receiving mental health outpatient treatment services

Priority Type: MHS

Population(s): SMI, Other (LGBTQ, Homeless, Asian, Tribal communities, Native Hawaiian/Other Pacific Islanders, Underserved Racial and Ethnic Minorities)

Goal of the priority area:
Increase the number of adults with SMI accessing mental health outpatient services.

Objective:
• Require MCOs, BHASOs, and BHOs 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: Increase mental health outpatient services for adults with SMI

Baseline Measurement: SFY20: 192,662 adults with SMI received mental health outpatient services

First-year target/outcome measurement: Maintain a minimum of 104,128 adults with SMI receiving mental health outpatient services in SFY22 (we anticipate a decrease in numbers, bringing us closer to our normal baseline as Covid decreases)

Second-year target/outcome measurement: Maintain a minimum of 104,128 adults with SMI receiving mental health outpatient services in SFY22 (we anticipate a decrease in numbers, bringing us closer to our normal baseline as Covid decreases)

	SFY 2020
Target/Outcome Measure	103,668
Results	192,662

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

			Description of Data: Fiscal Year 2020 clients served is an unduplicated count of adults with SMI (persons 18 years of age and older) served in publicly funded mental health outpatient programs 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 #: 7* **Priority Area:** Increase the number of individuals receiving recovery support services, including increasing supported employmentand supported housing services for individuals with SMI, SED, and SUD **Priority Type:** SAT, MHS **Population(s):** SMI, SED, PWWDC, PWID, TB, Other (Homeless, Asian, Tribal communities, Native Hawaiian/Other Pacific Islanders, Underserved Racial and Ethnic Minorities) **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 (formerly increase employment services)

Baseline Measurement: FY2020 **–** need data

First-year target/outcome measurement: Increase average number of people receiving supported employment services per month (over 12-month period) by 5% in FY22 (additional ??)

Second-year target/outcome measurement: Increase number of people receiving supported employment services per month (over 12-month period) by 5% in FY23 (additional ??)

	SFY 2020
Target/Outcome Measure	Increase 5% (additiona
Results	No Data available yet

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 services *(formerly decrease homelessness)*

Baseline Measurement: FY2020 **–** need data

First-year target/outcome measurement: Decrease by 5% (?? fewer)

Second-year target/outcome measurement: Decrease by 5% (?? fewer)

	SFY 2020
Target/Outcome Measure	Decrease by 5% (808 f

Results	67,604

Notes: The way this was previously worded, it was not necessarily a BG priority – a lot of problems with obtaining data and the definition

Recommendation to take out # of individuals employed – ESD data – we need number of individuals who received BH services that were recorded as homeless.

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 #: 8

Priority Area: Increase the number of adults receiving outpatient substance use disorder treatment

Priority Type: SAT

Population(s): PWWDC, PWID, TB, Other (LGBTQ, Criminal/Juvenile Justice, Homeless, Asian, Tribal communities, Native Hawaiian/Other Pacific Islanders, Underserved Racial and Ethnic Minorities)

Goal of the priority area:
Increase the number of adults receiving outpatient SUD treatment including adults who are using opioids and other prescription drugs.

Objective:
• Require the Behavioral Health Organizations (BHOs) 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 services.

Annual Performance Indicators to Measure Goal Success

Indicator #: 1

Indicator: Increase outpatient SUD for adults in need of SUD treatment

Baseline Measurement: SFY20: 40,293

First-year target/outcome measurement: Increase the number of adults in SFY22 to 47,875

Second-year target/outcome measurement: Increase the number of adults in SFY23 to 48,888.

	SFY 2020 (General Adu Population)
Target/Outcome Measure	47,875
Results	40,293

Results:
We did not reach out target outcomes, do we want to adjust the target measurement outcomes?

Data Source:
The number of adults receiving SUD outpatient services is tracked using the Behavioral Health Administration (BHA) 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 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. Indian Health Care Providers have to enter into multiple systems which can be burdensome.

			Priority #: 9 **Priority Area:** Pregnant and Parenting Women **Priority Type:** SAT **Population(s):** Pregnant and Parenting Women (PWW) **Goal of the priority area:** Increase the number of PPW clients receiving case management services **Objective:** Improve the health of pregnant and parenting women 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:** As of June 2021, the total contracted number of PPW clients receiving PCAP case management services is 1409. **First-year target/outcome measurement:** Increase the number of PPW clients receiving PCAP case management services (an estimated increase of anywhere from 82-92 client slots, depending on the per client rate determined per county) **Second-year target/outcome measurement:** Maintain the number of 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:** - Impacts of the current/ongoing COVID pandemic. - If funding is reduced for any reason, the number of sites/clients served may decrease. *Priority #: 10* **Priority Area:** Maintain Government to Government relationships with Tribal Governments **Priority Type:** SAP, SAT **Population(s):** PWWDC, PP, PWID, TB, Other (Underserved Racial and Ethnic Minorities) **Goal of the priority area:** Adhere to the Washington State Centennial Accord and DSHS Administrative Policy 7.01 which directs DSHS Administrations to communicate, collaborate, and formally consult with the 29 Federally Recognized Tribes when funding and policy changes will have an impact on Tribal Governments, Urban Indian Health Programs, Recognized American Indian Organizations, and individual American Indians/Alaska Natives. By extension of the Accord and Policy, DBHR gives all 29 Tribes the opportunity to apply for block grant funding to help bolster prevention and treatment services within their tribal communities. **Objective:** • Support the Tribes to use block grant funding for the following services for youth and adults who are non-Medicaid and low income: assessments, case management, drug screening tests including urinary analysis, outpatient and intensive outpatient, and individual and group therapy; • Support the Tribes to use block grant funding to begin and/or maintain tribal substance use disorder prevention programs and projects for youth within tribal communities. **Strategies to attain the objective:** • Each tribe is required to complete a Tribal Plan and budget that indicates how the funding will be expended on approved SUD prevention or treatment activities, and DBHR must approve each plan and each update to a Tribal Plan.

			• Each tribe must submit quarterly expenditure reports to DBHR. • Each tribe must input 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. • DBHR will work in good faith with the Tribes and Urban Indian Health Programs to streamline the data reporting process in the future. • Each tribe must submit 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. **Annual Performance Indicators to measure goal success** **Indicator #:** 1 **Indicator:** Maintain treatment and prevention to American Indian/Alaska Natives **Baseline Measurement:** Treatment 4,872 **First-year target/outcome measurement:** Treatment 4,872 **Second-year target/outcome measurement:** Treatment 4,872 Results: **AI/AN Clients Served*:** **All tribal agencies reported into BHDS: 4,499 in SFY 2020 (3,401 in SFY 2021)** **SUD Prevention + MH Promotion AI/AN Clients Served:** **a) SUD Prevention: 11,505 in SFY 2020** **b) MH Promotion: 4,753 in SFY 2020 (no data available yet for SFY 2021)** **Do these targets make sense? Do we want to adjust them for the 22-23 app? We did not quite meet it, do we want to acknowledge the challenge of COVID?** **Data Source:** The Substance Use Disorder Prevention and Mental Health Promotion MIS and TARGET, or its successor, for treatment counts. **Description of Data:** As reported into TARGET by Tribes, total number of AI/AN clients served between July 1, 2019 and June 30, 2020. **Data issues/caveats that affect outcome measures:**

Behavioral Health Advisory Council

			Indian Health Care Providers have to enter into multiple systems which is burdensome.
4.	**Break**	All	
5.	**Membership Committee – New Members**	Vanessa Lewis	• Only 1 membership member currently (Vanessa Lewis). Tori will send a follow up email looking for members for the committee. • Katie Mirkovick will join the membership committee.
6.	**Peer Review Team**	Josh Wallace	• Difficult to pull together but will need a couple of people to review. • Vanessa Lewis, Josh, Katie, Mary • Tori to send follow up to committee to look for additional members.
7.	**Directors Update**	Keri Waterland	• Not a lot of change between now and May • DBHR is still working on the 74-line items that the legislature gave the division. Not all are new investments, but most are. It takes time to strategically think through all of the different projects that DBHR now has responsibility for. • Blake piece has work group and steering committee and is currently under way - Tony Walton is the project manager. • 988 bill – strategic outreach to various agencies and entities. Currently working on collecting applications from BH-ASO's, Peer's, individual with lived experience – for the workgroups. • DBHR is doing a lot of work around the ARPA funds – working on getting them through contracts to get the funds out the door. They are limited in nature, so DBHR is working on making sure they are getting the contracts up and running. • Having concerns around the interplay with individuals who have needs for support around BH and crisis system and the role with local law enforcement; DBHR is collecting that information. • DBHR is working on decision packages internally and working with leadership. • A DP is a ask to Office of Financial Management around funding to expand program • Working on agency request legislature – an opportunity to look at projects that we need to ask for legislative changes on. Gives DBHR an opportunity to be creative or to fix problems that may have been overlooked at the last session. • A significant improvement for the HCA had over 85% of contracts got out on time. The remaining

			contracts and getting worked on and will be out soon. • Trying to get block grant enhancement funds out in contracts. • Keeping momentum in the projects of BG Enhancement, by continuing them with the ARPA funds. • SUD funds did not come in as high as normal. • DBHR has a multitude of different trainings coming up this summer, they will keep BHAC updated. • DBHR is heavily recruiting, one of the roles in the navigator administrator, we have the month of July to establish the standards to Keri to detail what the navigator program will look like. Administrators are already being hired. Anticipate this happening late summer and early fall. • Updates on Workforce development and the campaign – Campaign is under development, we need to go live by September to be able to spend down the funds. • DBHR questions to BHAC – we have sunset our all-provider calls related to COVID – what are som,e of the successes and challenges of COVID related impacts? • One of the biggest concerns from Josh is that concern for safety and the heightened mental health. • Mary O'Brian – have a heightened amount of request of services in their area. Correlates with schools opening in person again. Lots of individuals are having a hard time adjusting to the new "normal". All people need support in this time.
8.	**Guest Legislature – Senator Judy Warnick**	Richelle Madigan & Senator Judy Warnick	• Richelle Madigan has played a role in Senator Warnicks role in BH. • Has been apart of workgroups to be able to bnring awareness to this. • Bill 5412 – Redefining what a parent and family look like, someone who may have a strong family relationship with a child. • Part of the definition needed to be clarified – what is the age of consent of children? • Bill did not go through, Senator Dingra asked that Warnick go back and work on the bill a little bit before the next session. Currently there is interest in the bill and continuing the conversation. • Meet with committee Staff and Caucus staff attended a webinar about CBT – Warnick now wants to include this to the bill. Finding therapy, finding facilities

			• We do not have facilities for children, we do not have the appropiate staff for the facilities as well. The state and legislature has a work to do. • Starting with State Hospitals, then go in for early interventions (age 16-24). • Very interested in bringing in school districts. What can they supply as far as health for these students? • What can BHAC do? Take a look at bill 5412, what suggestions do you have as a council? • Equine therapy, Senator Warnick has seen the effects of therapy for the children. • Senator Warnick wants to use a wholistic approach, therapy should be more than just sitting in an office and talking with a professional. • New outside of the box type of treatment, not sure if it will be apart of 5412 but it could potentially be apart of the bill. • Richelle – Working with Senator Warnick with getting her Sons treatment plan worked out.
9.	**Action Item Recap** **September Agenda Items** **Ajourn**	All	Section update: workforce Steve Perry Continue to invite legislatures. Senator Dingra, Tom Dan, look on the east side of the mt as well Director's update Block grant update – final application.

Environmental Factors and Plan

Advisory Council Members

For the Mental Health Block Grant, **there are specific agency representation requirements** for the State representatives. States MUST identify the individuals who are representing these state agencies.

State Education Agency
State Vocational Rehabilitation Agency
State Criminal Justice Agency
State Housing Agency
State Social Services Agency
State Health (MH) Agency.

Start Year: 2022 End Year: 2023

Name	Type of Membership	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Payton Bordley	Youth/adolescent representative (or member from an organization serving young people)		171 N Tribe Center RD Skokimish Nation WA, 98584 PH: 360-490-7728	payton@skokomish.org
Julierae Castelton	Providers			
Janet Cornell	State Employees	Health Care Authority		janet.cornell@hca.wa.gov
Carolyn Cox	Parents of children with SED/SUD		7701 W 4th Ave Kennewick WA, 99336 PH: 509-792-9348	carolyn.cox97@yahoo.com
Beth Dannhardt	Others (Advocates who are not State employees or providers)		851 Cutler Way Zillah WA, 98953 PH: 509-961-3949	bdannhardt@gmail.com
Jeff Green	State Employees	Social Services		greenjd@dshs.wa.gov
Dixie Grunenfelder	State Employees	Office of Superintendent of Public Instruction		dixie.grunenfelder@k12.wa.us
Becky Hammill	Providers		1002 Spokane WA, 99702 PH: 509-892-9241	bhammill@passagesfs.org
Karen Huber	State Employees	Office of Insurance Commissioner		karenh@oic.wa.gov
Ryan Keith	State Employees	Health Care Authority		ryan.keith@hca.wa.gov
Ahney King	Providers			
Steve Kutz	Representatives from Federally Recognized Tribes		IPAC Tribal Representative	skutz.health@cowlitz.org
Susan Kydd	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		4513 Lakeridge Dr E Lake Tapps WA, 98391 PH: 206-940-0339	kyddsusan08@gmail.com
Michael Langer	State Employees	Health Care Authority		michael.langer@hca.wa.gov

Ruth Leonard	State Employees			
Vanessa Lewis	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		6486 19th St W Fircrest WA, 98466 PH: 253-830-4709	vlewis@wapave.org
Richelle Madigan	Parents of children with SED/SUD		19527 Rd SNE Moses Lake WA, 98837 PH: 509-770-1218	richelle_madigan@hotmail.com
Victoria McDermott Hale	State Employees	Health Care Authority		
Sharon McKellery	Parents of children with SED/SUD		5211 Solberg Dr SW Lakewood WA, 98499 PH: 205-766-9977	sharonmckellery@gmail.com
Taku Mineshita	State Employees	Department of Children, Youth and Families		taku.mineshita@dcyf.wa.gov
Katie Mirkovich	State Employees	DSHS/Vocational Rehabilitation		katie.mirkovich@dshs.wa.gov
Marcia Mongrain-Finkas	Family Members of Individuals in Recovery (to include family members of adults with SMI)		670 Finkas Rd Toutle WA, 98649 PH: 360-751-2605	mongrainfinkas@gmail.com
Maria Nunez	Youth/adolescent representative (or member from an organization serving young people)		601 Cereza C Pasco WA, 99301 PH: 509-591-7422	mariaelenan2706@gmail.com
Mary O'Brien	Providers		910 E. Mead Yakima WA, 98903 PH: 509-453-1344	maryo@yvfwc.org
Jenni Olmstead	State Employees	Department of Children, Youth and Families		jenni.olmstead@dcyf.wa.gov
Nelson Rascon	Parents of children with SED/SUD		2119 S M St Tacoma WA, 98405 PH: 253-230-3558	nrascon@dadsmove.org
Michael Reading	Others (Advocates who are not State employees or providers)		BHO - King County	mreading@kingcounty.gov
Tana Russell	Providers			
Pamala Sacks-Lawlar	State Employees	Social Services		sackspa@dshs.wa.gov
Kristina Sawyckyj	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			sawyckyjkristina@yahoo.com
Jeff Spring	State Employees	Department of Commerce - Housing		jeff.spring@commerce.wa.gov
Dennis Swennumson	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		5 South Cedar Spokane WA, 99201 PH: 509-768-5466	dennisswennumson@gmail.com
Haley Tibbits	Family Members of Individuals in Recovery (to include family members of adults with SMI)		6508 NE 112th St Vancouver WA, 98686 PH: 360-635-8776	hgibbits@telecarecorp.com

Josh Wallace	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			josh@peerseattle.org
Keri Waterland	State Employees	Health Care Authority		
Shelli Young	Parents of children with SED/SUD		3644 Friancis Ave N Seattle WA, 98103 PH: 206-276-9700	shellsbox@hotmail.com

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Advisory Council Composition by Member Type

Start Year: 2022 End Year: 2023

Type of Membership	Number	Percentage
Total Membership	**34**	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	5	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	2	
Parents of children with SED/SUD*	5	
Vacancies (Individuals and Family Members)	0	
Others (Advocates who are not State employees or providers)	2	
Persons in recovery from or providing treatment for or advocating for SUD services	0	
Representatives from Federally Recognized Tribes	1	
Total Individuals in Recovery, Family Members & Others	**15**	**44.12%**
State Employees	14	
Providers	5	
Vacancies	0	
Total State Employees & Providers	**19**	**55.88%**
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	**0**	
Youth/adolescent representative (or member from an organization serving young people)	2	

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

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

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22. Public Comment on the State Plan - Required

Narrative Question

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

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

a)	Public meetings or hearings?	○ Yes ● No
b)	Posting of the plan on the web for public comment?	● Yes ○ No
	If yes, provide URL:	
	https://www.hca.wa.gov/about-hca/behavioral-health-recovery/block-grants	
c)	Other (e.g. public service announcements, print media)	○ Yes ● No

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23. Syringe Services (SSP)

Narrative Question:

The Substance Abuse Prevention and Treatment Block Grant (SABG) restriction[1,2] on the use of federal funds for programs distributing sterile needles or syringes (referred to as syringe services programs (SSP)) was modified by the **Consolidated Appropriations Act**, 2018 (P.L. 115-141) signed by President Trump on March 23, 2018[3].

Section 520. *Notwithstanding any other provisions of this Act, no funds appropriated in this Act shall be used to purchase sterile needles or syringes for the hypodermic injection of any illegal drug: Provided, that such limitation does not apply to the use of funds for elements of a program other than making such purchases if the relevant State or local health department, in consultation with the Centers for Disease Control and Prevention, determines that the State or local jurisdiction, as applicable, is experiencing, or is at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, and such program is operating in accordance with State and local law.*

A state experiencing, or at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, (as determined by CDC), may propose to use SABG to fund elements of an SSP other than to purchase sterile needles or syringes. States interested in directing SABG funds to SSPs must provide the information requested below and receive approval from the State Project Officer. Please note that the term used in the SABG statute and regulation, *intravenous drug user* (IVDU) is being replaced for the purposes of this discussion by the term now used by the federal government, *persons who inject drugs* (PWID).

States may consider making SABG funds available to either one or more entities to establish elements of a SSP or to establish a relationship with an existing SSP. States should keep in mind the related PWID SABG authorizing legislation and implementing regulation requirements when developing its Plan, specifically, requirements to provide outreach to PWID, SUD treatment and recovery services for PWID, and to routinely collaborate with other healthcare providers, which may include HIV/STD clinics, public health providers, emergency departments, and mental health centers[4]. SAMHSA funds cannot be supplanted, in other words, used to fund an existing SSP so that state or other non-federal funds can then be used for another program.

In the first half of calendar year 2016, the federal government released three guidance documents regarding SSPs[5]: These documents can be found on the Hiv.gov website: **https://www.hiv.gov/federal-response/policies-issues/syringe-services-programs**,

1. **Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016** from The US Department of Health and Human Services, Office of HIV/AIDS and Infectious Disease Policy **https://www.hiv.gov/sites/default/files/hhs-ssp-guidance.pdf** ,
2. **Centers for Disease Control and Prevention (CDC)Program Guidance for Implementing Certain Components of Syringe ServicesPrograms,2016** The Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention, Division of Hepatitis Prevention **http://www.cdc.gov/hiv/pdf/risk/cdc-hiv-syringe-exchange-services.pdf**,
3. **The Substance Abuse and Mental Health Services Administration (SAMHSA)-specific Guidance for States Requesting Use of Substance Abuse Prevention and Treatment Block Grant Funds to Implement SSPs** **http://www.samhsa.gov/sites/default/files/grants/ssp-guidance-state-block-grants.pdf** ,

Please refer to the guidance documents above and follow the steps below when requesting to direct FY 2021 funds to SSPs.

- **Step 1** - Request a Determination of Need from the CDC
- **Step 2** - Include request in the FFY 2021 Mini-Application to expend FFY 2020 - 2021 funds and support an existing SSP or establish a new SSP
    - Include proposed protocols, timeline for implementation, and overall budget
    - Submit planned expenditures and agency information on Table A listed below
- **Step 3** - Obtain State Project Officer Approval

Future years are subject to authorizing language in appropriations bills.

End Notes

[1] Section 1923 (b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-23(b)) and 45 CFR § 96.126(e) requires entities that receive SABG funds to provide substance use disorder (SUD) treatment services to PWID to also conduct outreach activities to encourage such persons to undergo SUD treatment. Any state or jurisdiction that plans to re-obligate FY 2020-2021 SABG funds previously made available such entities for the purposes of providing substance use disorder treatment services to PWID and outreach to such persons may submit a request via its plan to SAMHSA for the purpose of incorporating elements of a SSP in one or more such entities insofar as the plan request is applicable to the FY 2020-2021 SABG funds ***only*** and is consistent with guidance issued by SAMHSA.

[2] Section 1931(a(1)(F) of Title XIX, Part B, Subpart II of the Public Health Service (PHS) Act (42 U.S.C.§ 300x-31(a)(1)(F)) and 45 CFR § 96.135(a)(6) explicitly prohibits the use of SABG funds to provide PWID with hypodermic needles or syringes so that such persons may inject illegal drugs unless the Surgeon General of the United States determines that a demonstration needle exchange program would be effective in reducing injection drug use and the risk of HIV transmission to others. On February 23, 2011, the Secretary of the U.S. Department of Health and Human Services published a notice in the Federal Register (76 FR 10038) indicating that the Surgeon General of the United States had made a determination that syringe services programs, when part of a comprehensive HIV prevention strategy, play a critical role in preventing HIV among PWID, facilitate entry into SUD treatment and primary care, and do not increase the illicit use of drugs.

[3] Division H Departments of Labor, Health and Human Services and Education and Related Agencies, Title V General Provisions, Section 520 of the Consolidated Appropriations Act, 2018 (P.L. 115-141)

[4] Section 1924(a) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(a)) and 45 CFR § 96.127 requires entities that receives SABG funds to routinely make available, directly or through other public or nonprofit private entities, tuberculosis services as described in section 1924(b)(2) of the PHS Act to each person receiving SUD treatment and recovery services.

Section 1924(b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(b)) and 45 CFR 96.128 requires "designated states" as defined in Section 1924(b)(2) of the PHS Act to set- aside SABG funds to carry out 1 or more projects to make available early intervention services for HIV as defined in section 1924(b)(7)(B) at the sites at which persons are receiving SUD treatment and recovery services.

Section 1928(a) of Title XXI, Part B, Subpart II of the PHS Act (42 U.S.C. 300x-28(c)) and 45 CFR 96.132(c) requires states to ensure that substance abuse prevention and SUD treatment and recovery services providers coordinate such services with the provision of other services including, but not limited to, health services.

[5]***Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016*** describes an SSP as a comprehensive prevention program for PWID that includes the provision of sterile needles, syringes and other drug preparation equipment and disposal services, and some or all the following services:

- Comprehensive HIV risk reduction counseling related to sexual and injection and/or prescription drug misuse;
- HIV, viral hepatitis, sexually transmitted diseases (STD), and tuberculosis (TB) screening;
- Provision of naloxone (Narcan?) to reverse opiate overdoses;
- Referral and linkage to HIV, viral hepatitis, STD, and TB prevention care and treatment services;
- Referral and linkage to hepatitis A virus and hepatitis B virus vaccinations; and
- Referral to SUD treatment and recovery services, primary medical care and mental health services.

Centers for Disease Control and Prevention (CDC) Program Guidance for Implementing Certain Components of Syringe Services Programs, 2016 includes a **description of the elements of an SSP** that can be supported with federal funds.

- Personnel (e.g., program staff, as well as staff for planning, monitoring, evaluation, and quality assurance);
- Supplies, exclusive of needles/syringes and devices solely used in the preparation of substances for illicit drug injection, e.g., cookers;
- Testing kits for HCV and HIV;
- Syringe disposal services (e.g., contract or other arrangement for disposal of bio- hazardous material);
- Navigation services to ensure linkage to HIV and viral hepatitis prevention, treatment and care services, including antiretroviral therapy for HCV and HIV, pre-exposure prophylaxis, post-exposure prophylaxis, prevention of mother to child transmission and partner services; HAV and HBV vaccination, substance use disorder treatment, recovery support services and medical and mental health services;

- Provision of naloxone to reverse opioid overdoses
- Educational materials, including information about safer injection practices, overdose prevention and reversing an opioid overdose with naloxone, HIV and viral hepatitis prevention, treatment and care services, and mental health and substance use disorder treatment including medication-assisted treatment and recovery support services;
- Condoms to reduce sexual risk of sexual transmission of HIV, viral hepatitis, and other STDs;
- Communication and outreach activities; and
- Planning and non-research evaluation activities.

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Footnotes:

At this time we are not requesting to direct funds to SSPs.

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Syringe Services (SSP) Program Information-Table A

If the state is planning to expend funds from the COVID-19 award, please enter the total planned amount in the footnote section.

Syringe Services Program SSP Agency Name	Main Address of SSP	Planned Dollar Amount of SABG Funds Expended for SSP	SUD Treatment Provider (Yes or No)	# Of Locations (include mobile if any)	Narcan Provider (Yes or No)
No Data Available					

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Footnotes:

We do not plan to use funding for SSP at this time.