Washington State

UNIFORM COMBINED APPLICATION
FY 2026 – FY 2027
STATE BEHAVIORAL HEALTH ASSESSMENT
AND PLAN

SUBSTANCE USE PREVENTION TREATMENT AND RECOVERY SERVICES
and
COMMUNITY MENTAL HEALTH SERVICES
BLOCK GRANTS

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

and

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

ASSESS THE STRENGTHS AND NEEDS OF THE BEHAVIORAL HEALTH SYSTEM

Provide an overview of the state's prevention system (description of the current prevention system's attention to individuals in need of substance use primary prevention), early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state's Application. Describe how the public behavioral health system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of mental health and SUD services. States should also include a description of regional, county, tribal, and local entities that provide mental health and SUD services or contribute resources that assist in providing these services. This narrative must include a discussion of the current service system's attention to the MHBG and SUPTRS BG priority populations listed above under "Populations Served."

Please describe how the public mental health and substance use services system is currently organized at the state level, differentiating between child and adult systems.

Public Behavioral Health System in Washington

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

Community Behavioral Health System - Overview

The purchasing and administration for Medicaid and publicly funded behavioral and physical health resides with the single state authority Washington State Health Care Authority (HCA).

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

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

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

Effective July 1, 2017, DBHR established a fee-for-service program for behavioral health services, specifically for individuals that do not chose to opt into managed care or have unique circumstances which do not allow them to participate in managed care. Federal law ensures that AI/AN individuals are not required to opt into managed care, and HCA implemented this program to follow this law. American Indians/Alaska Natives receiving Washington Apple Health (Medicaid) coverage have the choice to receive their treatment of mental health and substance use disorder either through the managed care program or through the Apple Health fee-for-service (FFS) program. These individuals now have the freedom of choice of any behavioral health provider participating in the fee-for-service program and currently accepting patients. There are approximately 300 non-tribal providers, statewide, participating as FFS providers. If AI/AN Apple Health clients are eligible to receive care at an Indian Health Service (IHS) facility, Tribal health program, or urban Indian health program, this change does not affect their ability to receive care at those programs.

State Psychiatric Hospitals

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

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

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

Other State Agencies, Tribal Governments, and Key Partners

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

- Aging and Long-Term Support Administration, Department of Social and Health Services
- Developmental Disabilities Administration, Department of Social and Health Services
- Department of Children, Youth, and Families
- Juvenile Rehabilitation, Department of Social and Health Services
- Department of Health

- Department of Corrections
- Veterans Administration
- Division of Vocational Rehabilitation
- The University of Washington Alcohol and Drug Abuse Institute
- The Office of Superintendent of Public Instruction
- Liquor and Cannabis Board
- Tribal governments and other tribal partners
- Urban Indian Health Programs (UIHP)s and urban Indian organizations

Please describe the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of mental health and substance use services.

As Washington's State Mental Health Authority (SMHA) and Single State Authority (SSA) the Health Care Authority (HCA) integrates physical and behavioral health care to advance whole-person, value-based care. Through the Division of Behavioral Health and Recovery (DBHR), HCA funds, trains, and supports community-based providers delivering prevention, intervention, treatment, recovery, and problem gambling services. Partnering with community, state, and national stakeholders, HCA is committed to evidence-based, cost-effective, person-centered approach that improves outcomes for individuals and families.

Some of the key services DBHR provides are:

- Substance Use Disorder Prevention
- Early Intervention
- Outreach, engagement, crisis services
- Outpatient substance use disorder and mental health services

- Inpatient/residential substance use disorder and mental health services
- Mental health promotion (funded with General Fund-State)
- Recovery support services
- Problem gambling services
- Behavioral Health and Prevention, Pre-natal through 25
- Transition supports, and stabilization
- Supported Employment
- Supportive Housing
- Supported Education

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

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

- The top 5-7 percent of the Medicaid population are expected to have the highest medical expenditures for eligibility for health home services.
- Foster youth with complex medical and behavioral health needs.

- People 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 supplemental security income (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 include but are not limited to client support funds, Recovery Cafes, peer support, and housing resources for individuals transitioning from inpatient settings, Supportive Housing and Supported Employment.

- Using the information learned in the intensive outpatient and partial hospitalization pilot projects to roll out this treatment option to all eligible individuals

- Expanding our efforts to develop sustainable infrastructure for school based mental health programs and services through continuing our work with the Washington office of superintendent of public instruction (OSPI) on the Project AWARE grant as well as adding four other grant sites across the state that include school districts and Educational Service Districts (ESDs).

- Center of Parent Excellence that supports parents with children and youth experiencing behavioral health with peer support, education, and supportive groups

- Kids Mental Health Washington (KMHWA), formerly Youth Behavioral Health Navigators, where regional teams are convening partners across the region to work on issues concerning children, youth and family behavioral health, and convening multidisciplinary teams to support individual families accessing and connecting with services

- DBHR collaboratively developed the State Strategic Plan for SUD Prevention and Mental Health Promotion with 25 other state agencies and organizations. This plan captures in detail the needs and resources for Washington's Behavioral Health promotion and prevention services.

- DBHR funds and supports through technical assistance and training community level strategic planning that includes localized needs and resources assessment in following the Strategic Prevention Framework.

- Creation of the Indian Nation Agreement, honoring tribal sovereignty and government to government principles. This agreement accounts for the ability for the Tribe to utilize federal and grant funds to address needs in their community as they see appropriate and allowable with the parameters of any federal or state purposes.

- Development and implementation of two post-inpatient transitional housing facilities designed for 18–24-year-olds who: (1) are exiting inpatient behavioral health treatment or have exited behavioral health treatment and are engaged in a recovery plan; and (2) have not secured long-term housing. This includes a contract with a transition support provider and coalition of young people with lived experience to provide information and support services related to safe housing and support services for youth exiting inpatient behavioral health treatment; and organizes community housing providers, tribes or tribal organizations, inpatient behavioral health discharge planners, and young persons with lived experience of behavioral health conditions or unaccompanied homelessness.

AN OVERVIEW OF THE CONTINUUM OF CARE

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

Prevention/Mental Health Promotion

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

Intervention

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

Mental Health Treatment

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

include Multi-systemic Therapy (MST), Wraparound and Multi-dimensional Treatment Foster Care (MDTFC), and Trauma-focused Cognitive Behavioral Therapy (TF-CBT).

Crisis Services

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

Washington Crisis Response and Recovery Services include:

- Mobile Rapid Response Crisis Teams (MRRCT) - in-person response for people in crisis, including SUD assessment
- Youth Mobile Rapid Response Crisis Teams – voluntary outreach for youth and families; provides crisis intervention, peer support, and in home stabilization to reduce facility-based care needs. Follows the developmentally appropriate SAMHSA and NASMHPD best practice model of Mobile Response and Stabilization Services (MRSS).
- Early Intervention and Stabilization – low-barrier services connecting individuals to natural and clinical supports, improving outcomes and reducing system strain
- Washington Recovery Helpline – 24/7 statewide emotional support, information, and referrals for substance use, problem gambling, and mental health concerns; operated by Seattle Crisis Clinic under a performance-based DBHR contract
- Teen Link – Peer-answered helpline each evening, providing youth-specific support
- Involuntary Treatment Evaluation – Designated Crisis Responders (DCRs) and Designated Chemical Dependency Specialists asses for involuntary psychiatric or SUD treatment and petitions courts when criteria are met
- Tribal Coordination – BH-ASOs must coordinate crisis services with tribal behavioral health providers (with ROI) to ensure continuity of care; tribal governments are expanding crisis response teams, tribal designated responders, and codes for involuntary treatment.

Substance Use Disorder (SUD) Treatment

Substance use disorder, co-occurring assessments use the American Society of Addiction Medicine (ASAM) criteria to help determine and match the individual to the appropriate level of care, and services that meet their needs. Depending upon medical necessity and individual need, outpatient, residential, or withdrawal management and stabilization can be the first entry point when receiving behavioral health services. ASAM will release an Adolescent and Transition Age Youth volume for the first time in 2026, highlighting the critical need to ensure

young people are appropriately assessed using a unique set of criteria. The state of Washington has begun work on an implementation plan, ensuring youth-serving SUD providers are prepared for these updates to the current treatment system. All SUD co-occurring providers are licensed and certified treatment agencies by the Department of Health (DOH), whether services are provided to individuals in their local community or in another region. If an individual meets criterion for residential substance use disorder, co-occurring treatment, a referral is made, and the clinician will help assist the individual in the process of being admitted to a residential treatment facility within the state. DBHR is a recipient of The Healthy Transitions Project and System of Care Expansion grants. The Healthy Transitions Project is designed to improve emotional and behavioral health functioning for transition-age youth (TAY) age 16-25. The individual must reside within the catchment area and have been diagnosed with serious emotional disturbance (SED) or serious mental illness (SMI) including those experiencing a co-occurring disorder. This program aims to develop non-traditional recovery support services and engage TAY that might otherwise not access services. The System of Care Expansion grant provides day support services, therapeutic foster care services, aids 2 regions in robust implementation of Mobile Response and Stabilization Services (MRSS), support the expansion of youth and family networks to inform implementation and provides respite services as a part of the crisis continuum.

SUD Family Navigators

The SUD Family Navigator project focuses on implementing Navigators statewide who can serve families and individuals of loved ones experiencing SUD, of all ages, to include training, certification, licensed supervision, and development of expertise in serving family members of youth and young adults with SUD in a community-based setting. To date, Washington state provides SUD Family Navigator services at six locations, with three state partners. Curriculum and training for SUD Family Navigators is provided by a parent-run organization and educates treatment providers and family members on the impacts of substance on the adolescent brain. The training modules include potential responses to substance misuse, peer supports available, laws and regulations, system navigation, and overall family wellness.

Collegiate Recovery Support Program

Collegiate Recovery Support program (CRS) offers students recovering or seeking recovery from substance use, a supportive higher education environment to reinforce their wellness goals. These programs provide support and positive community connections, recovery coaching and community meetings, behavioral health system and treatment navigation, and promote successful academic performance. Since its creation in 2020, CRS has expanded to seven collegiate sites statewide, at private, state, and community college settings. As part of the

program, Washington State University supplies training, guidance, and resources to collegiate site grant recipients as they create recovery programs.

Youth SUD, Co-Occurring Residential Treatment, Maintenance and Expansion

HCA holds direct contracts with all SUD residential programs that serve youth on Medicaid to maintain their residential treatment bed capacity. Funds can be used for recruitment and retention of staff, program development and enhancement, and training/education. As part of this contract and partnership, HCA holds quarterly learning collaboratives with the SUD Residential programs to ensure both programs and the communities they serve are adequately supported to provide quality and attuned programing. Funds have also been dedicated to assisting an organization in opening an SUD, co-occurring inpatient program.

Training and Technical Assistance

Contract with experts and organizations to offer training and technical assistance opportunities for behavioral health professionals who serve youth. Topics vary and are determined and informed by clinician feedback and community needs. Training and projects that have occurred include matching clinical interventions to individual readiness and increasing family engagement.

Pregnant and Parenting Women with 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).

Problem Gambling

DBHR is responsible for planning, implementing, and overseeing the Problem Gambling Program, which includes a free treatment program for eligible clients and their families. Funded

through state taxes on and contributions from commercial gambling and WALottery, the program has an advisory committee that provides guidance on prevention and treatment services. Services include educating the public about the potential risk of problem gambling, as well as funding clinical training on how to identify and treat individuals experiencing problem gambling and Gambling Disorder (DSM-5). The low-barrier program provides free outpatient treatment services for individuals who are assessed as needing and would benefit from treatment for a gambling addiction but are uninsured or underinsured for problem gambling treatment. The treatment program reimburses Certified Gambling Counselors and certified problem gambling agencies for assessment and treatment services with the goal of reducing the negative impacts of problem gambling within WA State, which can include family disruption/disintegration, financial problems and bankruptcies, losing employment or school opportunities, interpersonal violence, significantly increased risk of suicide, and a high rate of co-occurring disorders (substance use disorders and mental health issues). Individuals in treatment and recovery for problem gambling/Gambling Disorder work to focus on eliminating gambling impacts to their lives, rebuilding financial independence, improving self-confidence, and maintaining a healthier lifestyle, thereby reducing or eliminating a need for financial assistance from other state programs.

Please describe how the public mental health and substance use services system is organized at the regional, county, tribal and local levels. In the description, identify entities that provide mental health and substance use services, or contribute resources that assist in providing these services. This narrative must include a description of the current service system's attention to the MHBG and SUPTRS BG priority populations listed above under "Populations Served".

Grant Funded Programs

The Division of Behavioral Health and Recovery (DBHR) is a division within the Washington State Health Care Authority (HCA), designated as the single state authority for mental health and substance use disorder treatment. DBHR includes many grant funded services, and program supports for behavioral health prevention/promotion, early intervention, treatment, and recovery support services for individuals with substance use disorder, serious mental illness, serious emotional disturbance, and/or dual diagnoses.

DBHR programs and services include, but are not limited to:

- SUD Prevention
- MH Promotion

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

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

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.

Priority Populations

The Block Grants are an important driver to assist Washington State and DBHR to continue moving forward with the 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, individuals who have experienced a first episode of psychosis, as well as services for individuals in crisis.
- 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.

- Tuberculosis screening and education services offered for all SUD outpatient and residential provider agencies.

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 concern who are:
- Homeless or inappropriately housed
- Involved with the criminal justice system
- Living in rural or frontier areas of the state

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
- Prevention services
- Treatment services - Adult Behavioral Health system including addressing the opioid epidemic in Washington State
- Treatment services - 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.

Co-Occurring Disorders

Washington state has implemented a Behavioral Health Co-Occurring Disorder Specialist enhancement, granting certification to the individual to provide substance use disorder counseling subject to the practice's limitations.

Washington's Medicaid state plan has been revised to modernize the rehabilitative services section, which is the main section leveraged by our licensed behavioral health agencies. Historically, this section was written in two silos by different state agencies; 1) mental health services; and 2) substance use disorder services. Under integrated care, the state plan is now fully overseen by the HCA. This state plan revision was written in a more cohesive manner, to intentionally avoid siloing mental health and substance use disorder treatment. The new format paves the way for more strategic planning around true co-occurring services. Additionally, specific services, such as stabilization services and community integration have been broadened to allow for additional provider types such as substance use disorder professionals. Allowable provider types for substance use have also been broadened to both align and recognize the full scope of practice for licensed counselors and social workers, further paving the way for more integrated care and flexible use of our limited workforce. The state plan amendment went into effect January 2024. As we move forward into 2025, the next phase of our work will involve close collaboration with our tribal partners and stakeholders to consider additional changes to the state plan and existing Washington Administrative Codes to further bolster, define, and expand co-occurring services. Listening and collaboration with those who have received or are receiving services, as well as peers and others with lived experience will also be key to this work.

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

Primary Prevention Services

The Health Care Authority prioritizes funding for evidence-based and research-based strategies to prevent substance use disorders, while at the same time recognizing the importance of local innovation to develop programs for specific populations and emerging problems.

Funding for direct services is primarily disseminated via:

- County contracts
- Educational Service Districts (ESDs)
- School districts/schools
- Community-based organization contracts
- Inter-local contracts
- Sovereign Nation Agreements (SNA) with Washington State Federally Recognized tribes through the Office of Tribal Affairs (OTA)

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

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

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

HCA contracts with Educational Service Districts (ESDs) for the placement of Student Assistance Professionals (SAPs) in schools as part of CPWI to provide universal, selective, and indicated prevention and intervention services using SAMHSA's Student Assistance Framework as outlined in "Substance Abuse and Mental Health Services Administration: Student Assistance: A Guide for School Administrators." 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 Substance Use Prevention, Treatment and Recovery Services Block Grant (SUPTRS) prevention funds to support school-based prevention and intervention services. Funds support staff time in a middle and/or high school to provide both prevention and intervention services.

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

HCA has implemented many meaningful workforce development strategies with the assistance of SUPTRS funds that have been made available to SUD professionals both in the field as well as at HCA. These programs include the Substance Abuse Prevention Specialist Training (SAPST), hosted each year by HCA. HCA partners with numerous agencies to host trainings such as the Prevention Ethics Training, whose hours can be credited towards the Prevention Specialist Certification (CPP) which is validated by the Prevention Specialist Certification Board of Washington. All trainings that are offered to providers and contacts in the field are posted to a site, which is supported through block grant funds and serves as a communication conduit with providers and contractors. Additionally, SUPTRS funds contribute to the creation of the Technical Assistance and Training Center through partnership with University of Washington Social Development Research Group who provide on-going support and training matched with the fluctuating needs of the prevention workforce.

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

Prevention Summit and Youth Forum

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

In 2024, the Prevention Summit was hosted fully in-person in Seattle, Washington at the Westin.

Children And Youth Behavioral Health System

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

- Implementation of Wraparound with Intensive Services (WISe) emphasizes a wraparound approach to both high-level and other level need youth cases, adopting the Child and Adolescent Needs and Strengths (CANS) assessment tool to evaluate needs and strengths in multiple domains for young people in the WISe program.
- Washington State's First Episode Psychosis Initiative called New Journeys, placing emphasis on early intervention services for individuals experiencing early onset symptoms of schizophrenia.

- Family Peer Partner and Youth Peer Partner development in services and system development, including the Statewide Children's Behavioral Health Family Network and Statewide Behavioral Health Youth Network
- System of care guiding principles are:
    - Family driven
    - Individualized, strengths based, and evidence formed
    - Youth guided
    - Provided in the least restrictive environment
    - Community based
    - Accessible
    - Collaborative and coordinated across an interagency network
- The Bridge Coalition is a statewide collaboration between community-based housing providers, behavioral health discharge planners, other community-based professionals, and young people with lived experience. The group aims to increase the number of unaccompanied young people who return to the community with safe housing and services upon exiting an inpatient behavioral health facility. The Coalition is in development of return to community plans to assist in improving transitions from inpatient behavioral health facilities back into their communities. The plans ensure the plans are holistic, trauma informed and centered around youth and young adult voice and choice.

The state has established collaborations with other child and youth serving agencies in the state to address behavioral health needs as evidenced by the Children's Behavioral Health Governance Structure. Washington has implemented Family, Youth, and System Partner Round Tables (FYSPRTs) in each of its 10 regions. These convenings include tribal representatives, youth and family with lived experience in the children's behavioral health system, and representatives from these six youth-serving state partners: Rehabilitation Administration-Juvenile Rehabilitation (RA), Department of Health (DOH), Department of Children Youth and Families (DCYF), Health Care Authority (HCA), Office of Superintendent of Public Instruction (OSPI), and Developmental Disabilities Administration (DDA).

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

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

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

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

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

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

Mental Health Services

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

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

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

Treatment

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

Infant-early childhood mental health

In Washington state, young children (birth – age 5) have some of the highest rates of unmet mental health care needs. HCA has increased our efforts to develop policies and resources that support infant-early childhood mental health (IECMH) across the state. Some of our key accomplishments in SFY24-25 include:

- Training 670 Medicaid mental health providers and 450 allied professionals in the DC:0-5 and sponsoring the first Tribal-specific DC:0-5 trainings.
- Supporting 40 Medicaid mental health providers at 12 behavioral health agencies to participate in Child Parent Psychotherapy (CPP) training.
- Offering quarterly IECMH Provider Spotlight events that build community and share knowledge.
- Developing in-depth Medicaid billing guidance for IECMH services
- Strengthening Medicaid managed care contract language to support IECMH services.
- Conducting cutting-edge evaluation on the impacts of IECMH policy changes, utilizing Medicaid administrative data.

- Partnering with statewide referral programs and other state agencies to improve IECMH referral pathways.

- Participating in national TA opportunities through Zero to Three IECMH Finance & Policy Project.

- Conducting focus groups with almost 100 IECMH providers and using findings to develop IECMH priorities.

ADULT BEHAVIORAL HEALTH SYSTEM

Mental Health

Five managed care organizations (MCOs) contract with the Health Care Authority to provide a complete array of physical and behavioral health services to enrolled individuals with Medicaid. The list of possible services includes brief intervention, crisis services, family treatment, freestanding evaluation and treatment, individual and group treatment, high intensity treatment, medication management and monitoring, peer support, rehabilitation case management, mental health treatment in a residential setting, and stabilization services. In addition to these services, individuals may also receive the mental health services they formerly received via the MCOs prior to integration, such as those provided by clinicians in private practice or via primary care settings. Indian Health Care Plans also provide these services through MCO and Fee for Service payment models.

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

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

In most communities, crisis and involuntary services are highly integrated. Crisis services include a 24-hour crisis line and in-person evaluations for those presenting with mental health crises. Crises are to be resolved in the least restrictive manner and should include family and

significant others as appropriate and at the request of the individual. Washington will be substantially expanding mobile crisis outreach services including child/youth teams on a statewide basis. Recent legislation passed will improve availability of crisis relief centers, mobile crisis, and community-based crisis intervention services in the state with a goal of response times almost on par with other first responders. Washington is also integrating commercial payors into the crisis system to streamline access and improve availability of crisis services. ITA services include in-person investigation of the need for involuntary inpatient care. A person must meet legal criteria and have refused or failed to accept less restrictive alternatives to be involuntarily detained.

Voluntary and involuntary community inpatient services for adults are provided in community hospital psychiatric units and in freestanding Evaluation and Treatment facilities (E&Ts) authorized by the MCOs and BH-ASOs or billed directly to the state for individuals without a managed care plan.

In addition to community-based mental health services administered by HCA, DSHS's BHA also operates two state psychiatric hospitals serving adults who are civilly committed, 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. HCA, in coordination with BHA's Office of Forensic Mental Health Services, has implemented our state's first outpatient competency restoration program. These programs are operating in the Phased regions of the state as identified in the Trueblood Settlement Agreement. In 6 regions across the state, courts now have the option to order defendants determined to be appropriate and willing to participate in outpatient competency restoration. These services are contracted and provided by community-based behavioral health agencies. The Governor has directed that the two state hospitals 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 the transition of individuals back into the community.

Certified Community Behavioral Health Clinics

Washington is undergoing an exciting expansion process related to Certified Community Behavioral Health Clinics (CCBHCs). Washington applied and was approved for a planning grant from SAMHSA to develop the CCBHC model in preparation for a demonstration application late in calendar year 2025. The model incorporates nine core service areas to provide cohesive,

integrated care to any individual in Washington. The Health Care Authority plans to apply for a demonstration waiver for CCBHC. Notices of Award are expected in March of 2026. If Washington were not selected, HCA does plan to pursue a State Plan Amendment (SPA) to implement the model, with a goal go-live date of January 1st, 2027. This model serves Adults with Serious Mental Illness (SMI), Children with Serious Emotional Disturbances (SED), and all of the priority populations identified in our SUPTRS Block Grant. Any person can walk into, and receive services from, a CCBHC with or without insurance. This open-door availability allows for broad coverage of the needs of Washingtonians throughout the state.

Adult Substance Use Disorder Treatment

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

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

Residential and Outpatient Treatment

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

- Intensive inpatient treatment provides a concentrated program of individual and group counseling, education, and activities for people with SUD and their families. There are

currently 58 intensive inpatient residential providers with a total capacity of 1,893 beds. The BHOs may subcontract for intensive inpatient services. Each patient participating in this level of substance use disorder treatment receives a minimum of 20 hours of treatment services each week.

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

Persons who Inject Drugs (PWID)

Syringe Services Programs (SSP)

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

Block Grant and other federal funding is not utilized to support syringe service programs in Washington state.

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), Health Engagement Hubs, Health Support Teams (HST), 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, 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, shelters, etc. Currently, all OTNs are funded through the SAMHSA SOR grant.

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

Health Engagement Hubs (HEHs) are designed to serve as an all-in-one location for low-barrier medical, behavioral health, and social services for people who use drugs. Each HEH location serves people over 18 years of age with medical and behavioral health care, including primary care, with specific attention given to infectious diseases, wound care, reproductive health, overdose education and naloxone distribution, and access to medications for opioid use disorder. Additionally, outreach and care coordination are provided. These programs provide same day or next day access to MAT including buprenorphine and naltrexone and warm handoffs to OTPs. Between July 1, 2024 and June 30, 2025, Washington state launched five (5) health engagement hubs, serving geographically and culturally diverse areas and populations across the state.

Medication for opioid use disorder (MOUD) and Medication for alcohol use disorder (MAUD) in Jails Program

The MOUD/MAUD in Jails Program provides incarcerated individuals with an opportunity for an assessment, medication, and sustained treatment throughout incarceration and coordination to continue treatment upon release or if transferred to another correctional facility. All FDA approved medications for the treatment of OUD and/or AUD may be offered. Overall benefits may include reduced morbidity and mortality due to overdose, reduced re-offenses, reduced complications during withdrawal, improved jail staff safety, increased cost savings, reduced transfers to emergency departments, reduced custodial costs, and overall improved relationships among jail staff and incarcerated individuals. In FY25, the program expanded to include medication for alcohol use disorder (MAUD) and added five jails to the program. The goal of the program is to offer the same standard of care to all incarcerated individuals in Washington state county, city, and tribal jails, easing transfers and reentry into the community. Over 5,000 individuals with OUD were treated through this program who otherwise would not have received medication or services.

Withdrawal Management

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

- Sub-acute Detox can be done on an outpatient basis or can be clinically managed residential facilities that have limited medical coverage. The correct level of care will be determined depending on the substance that was being used, and the overall health of the individual. 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 a medically managed intensive inpatient treatment that has medical coverage by registered nurses and nurses with doctors available 24/7. There is full access to acute medical 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 BH-ASOs or MCOs.

Contingency Management

Contingency Management (CM) is an evidence-based behavioral intervention for stimulant use disorder, opioid use disorder and alcohol use disorder. Contingency management consists of a series of motivational incentives for meeting treatment goals. The motivational incentives may consist of cash equivalents, e.g., gift cards of low retail value, with restrictions placed on the incentives.

We contract with our partners at Washington State University (WSU) Promoting Research Initiatives in Substance Use and Mental Health (PRISM) to provide training and technical assistance to our designated sites which may include:

1. Three hours of consultation/planning with each site, including virtual meetings, phone calls, emails, which involves initial implementation planning, coordinating, and scheduling. Coaching calls: Coaching sessions for each site (up to 9 calls), as well as fidelity monitoring.

2. A virtual CM for Stimulants Overview Training: Trainers will provide a 1.5-hour training session focused on overview and introduction of Contingency Management (CM), including the description of the intervention, its principles, and the research evidence.

3. A virtual CM Nuts and Bolts Training: Trainers will provide a four-hour, in-depth CM training seminar. This training will provide sites with the tools needed to implement a CM program adapted to the needs of their setting. This training includes information about the essential elements of CM, point of care testing in CM, tracking rewards, and navigating regulatory guidance.

In July of 2023, Washington State's 1115 waiver request was approved by the Centers for Medicare and Medicaid Services (CMS). Under this wavier HCA will implement a new contingency management benefit for eligible Apple Health beneficiaries with a substance use disorder in eligible provider settings that elect and are approved by HCA to pilot the benefit. HCA has created a work group to implement the waiver. Washington State has distributed a readiness review for interested sites to apply, with new readiness reviews accepted for each State Fiscal Year. Washington will add a minimum of ten sites per year.

Tuberculosis Screening

Tuberculosis screening, testing and education is provided to individuals receiving SUPTRS funded SUD treatment. The services must include tuberculosis counseling, testing and provide for or refer individuals with tuberculosis for appropriate medical evaluation and treatment.

When an individual is denied admission to the tuberculosis program because of the lack of capacity, the provider will refer the individual to another provider of tuberculosis services. The provider must conduct case management activities to ensure the individual receives tuberculosis services.

Implementation of Secure Withdrawal Management and Stabilization Facilities

DBHR has implemented Secure Withdrawal Management and Stabilization Facilities (SWMS) and made changes to multiple aspects of the state's Involuntary Treatment Act amended the ITA to align the substance use disorder (SUD) involuntary treatment process with the existing mental health (MH) involuntary statutes.

SWMS are licensed as Residential Treatment Facilities, certified by Department of Health (DOH) to provide services for individuals detained under the ITA. These facilities can hold an individual detained for an initial detention of up to 120 hours, and up to 14 additional commitment days of withdrawal management and stabilizing care if ordered by the Superior Court. Changes to the ITA statutes in 2019 allowed for an individual to be detained for involuntary SUD treatment and then converted for MH treatment (or vice versa), without court intervention during the current detention or commitment period, if determined to be appropriate by the facility currently treating the individual.

Currently, three SWMS facilities are operating: Recovery Place Kent (RPK), American Behavioral Health Services (ABHS) Chehalis, and Lifeline Connections. There are two new facilities currently under construction, owned by The Lummi Nation, and Benton County. RPK, and Lifeline Connections facilities are dually licensed as both SWMS and Evaluation and Treatment facilities, with the possibility of providing both MH and SUD involuntary treatment for individuals without moving them to another facility.

To meet detention criteria under the ITA, an individual must be determined to meet at least one or more of the following as a result of a SUD: a likelihood of serious harm to themselves, to

others, or to the property of others, or that they are gravely disabled. Individuals in need of SUD treatment longer than the initial detention and 14-day commitment may be able to receive a 90- or 180-day court ordered ITA treatment, outpatient or residential treatment voluntarily, or under a less restrictive alternative court order.

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 SAMHSA grants to assist with these efforts.

Opioid Settlement Funds

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

Washington State identified the State Opioid and Overdose Response Plan as the collaborative framework where consensus recommendations on the use of opioid settlement dollars would be developed and submitted for consideration by the Governor's Office. The state legislature appropriates opioid settlement dollars for activities across the behavioral health continuum including prevention, treatment, and recovery support services.

The Washington State Opioid Response Grant IV (SOR IV Year 1)

September 30, 2024, through September 29, 2025.

Health Engagement Hubs

Health Engagement Hubs (HEHs), piloted in SFY 2024 and 2025, are designed to serve as an all-in-one location for medical, behavioral health, and social services for people with substance use disorders. Each HEH location serves people over 18 years of age with medical and behavioral health care. Additionally, outreach and care coordination are provided. These programs provide same day or next day access to MOUD including buprenorphine and naltrexone and warm handoffs to OTPs. Between July 1, 2024 and June 30, 2025, Washington state launched five health engagement hubs, serving populations across the state.

SOR IV: Washington State Allocation: $27,173,792 per year/three-year grant cycle

Total contracts: $25,760,546

- Prevention: $5,423,273
- Admin: $1,341,418
- Data: $1,066,250
- Treatment: $15,221,375
- Recovery Support Services: $5,062,184

Prevention— $5,423,273

1. Community Prevention and Wellness Initiative (CPWI) Expansion– P1

SOR IV partially funds 22 CPWI coalitions in high-need communities with the greatest risk for youth opioid, stimulant, or other drug use. Coalitions implement evidence-based prevention programs, alternative programs, community-based processes, environmental strategies, and information dissemination to serve their communities.

Student Assistance Prevention-Intervention Services Program (SAPISP)[2]: In partnership with the Education Service Districts (ESD), HCA provides 25 schools with a full-time Student Assistance Professional (SAP). SAP assists with school-based prevention and intervention services for universal prevention programming, indicated programs for the most at-risk students, and referral services.

1.1 Fellowship Program

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. Each Cohort will spend 3 months with DBHR in Olympia, WA gaining intensive state-level prevention experience, then will spend 3 months mentoring and shadowing with an existing CPWI site and then spend the last 4 months of their Fellowship with a new high-needs community beginning the CPWI Strategic Prevention Framework model.

2. Community Enhancement Grants-P2

HCA contracts with eight high-need communities that implement direct evidence-based prevention services, information dissemination, and environmental strategies, such as drug take-back events. Additionally, SOR IV funds provide financial support to additional community-based organizations' prevention programs.

3. Starts with One Public Education Campaign-P3

HCA implements the *Starts with One* campaign, which focuses on prescription opioid and other drug misuse prevention, safe storage, and return of medications. The *For Our Lives* campaign is designed in partnership with tribes, to educate tribal communities about opioid misuse prevention, overdose response, and treatment.

4. Prescriber Education, Training, and Workforce Development Enhancements— P5

HCA supports several conferences and other workforce development opportunities, such as the Region 10 Opioid Summit; WA State Prevention Summit; and the Spring Youth Forum.

5. Analysis of Evidence Based Practice (EBP) Project P6

Research, consultation, trainings, and technical assistance to promote the use of evidence-informed, and relevant programs, practices, and policies that prevent substance use disorder and promote mental health across the state.

Data: $1,066,2505

1.Community prevention evaluation-D1

Contract with WA State University (WSU) to develop and disseminate community and state level reports for ongoing CPWI Evaluation. Contract may include collection, synthesis, and/or reporting of data in various formats.

2. Substance Use Disorder and Mental Health Promotion Online Reporting System (Minerva))-D2

Support the development and maintenance of the system to track local data on prevention services, feeding into the overall evaluation of community prevention services.

3. Research & Data Analysis Division- D3

Contract with RDA for project evaluator, programmer analyst, and GPRA coordination services for data evaluation.

4. The WSU CM (Contingency Management) -D4

Red Cap Data Support team provides specialized assistance in managing research data using REDCap (Research Electronic Data Capture), a secure web application designed for building and managing online surveys and databases. This support is specifically tailored to meet the data needs of contingency management (CM) research conducted at Washington State University.

Treatment: $ 14,122,6681

1. Opioid Treatment Networks -T1

DBHR has contracted with 13 organizations to create Opioid Treatment Networks (OTNs) to provide: medication for individuals experiencing opioid use disorder (OUD); funding to build OTN infrastructure; funding for staff; funding for OUD medications; and facilitation to transition individuals to community providers. Initiation sites are the funding recipients and contract holders – distribution of funding to OTNs was prioritized based on data of highest need and location of project to reach the populations at most risk for overdose and death. Contracts are performance-based, and are based on the number of new inductions, retention and OTN size.

1.1 Contingency Management Training T1A

CM is an evidence-based behavioral intervention for substance use disorder. It provides incentives to individuals contingent upon objective evidence of the target behavior, such as a negative urine drug test, to increase the likelihood of these behaviors, which are essential components and outcomes of effective treatment. This contract will provide for training and fidelity monitoring of the OTNs and H&S.

1.2 Plymouth House T1B

Plymouth house will expand contingency management in opioid treatment network programs for people who have been diagnosed with a stimulant use disorder, opioid use disorder, alcohol use disorder, or co-occurring use disorder. This contract covers the payment for staff and education only.

2. OTN TA/Training – T2

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 regarding EBPs with Opioid Use Disorder, Stimulant Use Disorder and HIV and viral hepatitis.

3. OTN Tobacco Cessation - T3

DBHR contracts with the Department of Health (DOH) to provide services for SOR projects and SOR funded clients, including WA Tobacco Quitline services, such as phone counseling and nicotine replacement therapy, Tobacco Treatment Specialist (TTS) training for SOR contractor's staff and training for providers on cross-addiction and Quitline referrals processes. Also provides funding for one Tobacco and Opioid Treatment Coordinator for DOH.

4. Grants to Tribal Communities –T4

Tribal prevention and treatment grants to 21 tribes at $21,000 each total $441,000 and two Urban Indian Health Programs ($150,000), are designed to meet the unmet needs of previous state opioid tribal requests. Continuation of the statewide Opioid Response Workgroup ($20,000).

5. OUD Treatment Decision Re-entry Services & COORP –T5

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

6. WSU Contracted Services –T6 and P5 combined

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

7. Opioid Treatment Network Hub & Spokes –T7

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

8. Tribal Treatment – T8

Create and distribute media campaigns for tribes to build awareness related to MOUD treatment options for Native Americans). The goal of the project is to work collaboratively with recognized tribal governments to engage in MOUD services.

Recovery Support Services $ 5,158,355

1. Client-directed Recovery Support and Peer Services-R1 & R2

Contracted direct recovery support and peer services to Catholic Community Services in Burlington, Everett Recovery Café, Peer Washington, Comprehensive Healthcare in Walla Walla, Okanogan Behavioral Healthcare, Spokane Recovery Café, and Vancouver Recovery Café. Recovery support services will be person directed and will include peer services/recovery coaching, and recovery planning. Additional services (employment support, housing support, mentoring, dental care not covered by Medicaid, medical care not covered by Medicaid, basic needs, education support, etc.) will be based on each individual's need and request for support.

2. PathFinder Peer Project ($1,505,972 SOR) – R3

Provide outreach and engagement services to individuals who are homeless/risk of homelessness and suspected of Opiate Use Disorders (OUD) and/or Stimulant Use Disorder (SUD) in two environments, emergency rooms and homeless encampments. Assist individuals with suspected OUD/SUD to access Medication for Opiate Use Disorder (MOUD) Services, Intensive Out/In patient SUD treatment, access Medicaid and other governmental funding such as SNAP.

First Six months of SOR IV Year 1

1. Prevention

SOR IV prevention programs offer a wide array of services addressing opioid, stimulant, and other drug use among youth. The grant currently supports eight CBOs that offer direct evidence-based programs; information dissemination; and environmental strategies, such as promotion of secure and safe home storage of opioids and other prescription drugs. Other prevention strategies offered through SOR include training and workforce development for prevention providers and tribal programs developed with members of this community.

In the first half of SOR IV Year 1, CBOs reached nearly 400,000 Washingtonians through information dissemination efforts and a total of 4,208 individuals were served through evidence-based programs.

2. Treatment

Three SOR IV programs—H&S, OTNs, and COORP—were funded during this reporting period from September 30, 2024, through March 30, 2025, and they offer MOUD treatment outreach and inductions to individuals with OUD. These programs provided 3,062 MOUD treatment outreach and inductions to 2,868 unique. Of the clients receiving treatment inductions, 1,018 agreed to enroll in SOR IV. The majority (82 percent) of enrolled clients received buprenorphine.

Among the clients who provided an MOUD treatment induction, COORP was responsible for 557. COORP staff also identified another 204 clients with OUD or stimulant use disorder (StimUD) and referred them to substance use disorder treatment upon release from incarceration.

3. Recovery

Four SOR IV programs provide recovery support, peer, and referral services: RSS, PPF, COORP, and RPR. The RSS and PPF programs offer recovery or peer coaching and linkages to services such as recovery housing and employment services. During this reporting period, the RSS program enrolled 516 clients in the SOR program. The PPF program conducted outreach to 518 new and returning clients. Most RSS (73 percent) and all PPF clients received recovery or peer coaching. About one in five (19 percent) RSS clients received more than one service. For PPF, all clients engaged by the peer support staff receive peer coaching. In addition to peer coaching, and referrals for housing and employment supports, PPF clients also received referrals for

mental health services (38 percent of clients) and substance use disorder treatment (37 percent).

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

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

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

August 31,2021 to August 30, 2026, Funding from the SUPTRS Block Grant is allocated for naloxone distribution. This is part of the sustainability plan to continue naloxone distribution statewide.

SUD Peer Engagement

Peer Pathfinder Overview

Projects for Assistance in Transition from Homelessness (PATH) program is a long-standing program designed to outreach and assist eligible individuals with Serious Mental Illness (SMI) to access behavioral health and other essential services. PATH is administered by the Center for Mental Health Services, a component of the Administration for Healthy America, AHA, within the US Department of Health and Human Services.

Peer Pathfinder Project is built off the successful model of “(PATH). Peer Pathfinder expands services to people experiencing a substance use disorder (SUD). The project links individuals to treatment options including Medication for Opioid Use Disorder (MOUD).

The Peer Pathfinder teams consist of two Peer Counselors/Outreach Professionals who assist individuals in navigating services to address barriers to independence and recovery. These services address housing, financial resources, transportation, habilitation and rehabilitation services.

September 30, 2022 - June 2024, 2,391 total people were outreached and 81% were unsheltered at intake and all were at risk of overdose.

Clubhouse Overview

Clubhouse and Peer-Run Organization programs benefit both individuals and peer communities working toward recovery. Clubhouses and Peer-Run Organizations demonstrate positive clinical and social outcomes. These programs are based on core principles of peer support, self-empowerment, and functionality within a community setting.

A Clubhouse or Peer-Run Organization provides a restorative environment for people whose lives have been severely disrupted because of their behavioral health challenges, and who need the support of others who are in recovery to reach their own vision of recovery.

As of July 2024, the Clubhouses and Peer-run Program consist of forty-two (42) providers/ locations. This includes: (12) Clubhouses, (14) Recovery Community Organizations, (14) Recovery Cafes and (1) Tribal -Alternative Promising Practice.

As of July 2024, outcomes for SFY24 Number of enrollments: 9,584, basic needs assistance: 13,629, employment services: 3,243, educational services: 8,250, and average daily attendance: 4,635.

Adult Drug Court

Through a Department of Justice Award, the Health Care Authority has partnered with the Center for Justice Innovation (CJI) to develop and implement a comprehensive initiative called the Washington State Treatment Court Opioid and Overdose Response Plan. The plan focuses

on providing Washington's treatment courts with training and resources needed to improve adherence to the national best practice standards and address overdose risk among its target population. Here is a list of our projects under this award, which were accomplished or enhanced in state fiscal year 2025:

- Developed and implemented a statewide assessment tool to measure adherence to best practices and implement statewide assessment tools and training protocols for Washington's recovery courts

- Developed a role-based competency assessment for members of the therapeutic court team

- Launched a training and technical assistance website for Washington's therapeutic courts.

- Pilot a specialized drug court track within two Washington State Superior Adult Therapeutic Courts (Walla Walla County and Cowlitz County) to enhance responses to overdose and opioid use, including overdose prevention and rapid access to Medications for Opioid Use Disorder (MOUD).

Pre-arrest and Pre-trial Diversion Programs

HCA's Division of Behavioral Health and Recovery (DBHR) operates multiple programs that support community-based alternatives to jail and prosecution for people whose unlawful behavior stems from unmanaged substance use, mental health challenges, or extreme poverty. Collectively referred to as Diversion programs due to their shared utilization of the Law Enforcement Assisted Diversion (LEAD) model as a common operational framework, these programs seek to engage with individuals as early as possible along the Sequential Intercept Model (SIM).

The LEAD model originated in Seattle in 2011 and has continued to be guided by the Washington-based LEAD Support Bureau while it has been implemented both nationally and internationally. It is designed to provide care coordination for people with complex, ongoing, unmet behavioral health needs and/or income instability who may lack shelter/housing, income, food, health care, and social networks and for whom existing systems prove inaccessible, overly complicated, or insufficiently responsive. The model is founded on evidence-based core principles that include advancing safety and health by equipping communities with improved access to services. DBHR partners with the LEAD Support Bureau for the provision of technical assistance to the entities involved with administering or implementing these initiatives.

DBHR administers three Diversion programs:

- LEAD Grant program
- Arrest and Jail Alternatives Grant program (AJA)
- Recovery Navigator Program (RNP)

The two grant programs support local community-driven initiatives at the city or county level, with the LEAD grant program overseen by HCA staff and the AJA program operated in partnership with the Washington State Association of Sheriffs and Police Chiefs (WASPC) and the Criminal Justice Training Center (CJTC), while the Recovery Navigator Program partners with regional Behavioral Health Administrative Service Organizations (BH-ASOs) to implement peer-led Diversion programs in each of Washington's 39 counties.

Program goals for Diversion programs seek to reduce arrests, time spent in custody, utilization of emergency services, and/or recidivism for clients served by the program, while increasing access to and utilization of nonemergency community behavioral health services and the resilience, stability, and well-being for clients served. Diversion programs reduce costs for the legal system compared to processing cases as usual, diverting people with behavioral health needs who have had law enforcement contact away from jail and prosecution in the pre-booking phase.

Recovery Supports

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 celebrations, 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
- Other opioid recovery strategies

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, hosts a monthly webinar, publishes a monthly newsletter, 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. The peer support program is invested in growing a cadre of approved Certified Peer Counselor trainers and approved training organizations in Washington State. The Peer Support Program has created a process utilizing a mentoring toolkit. The toolkit includes core competencies for training and a system for coaching CPCs with two years' experience providing direct peer services to become CPC training mentees. The mentees are mentored and vetted by experienced CPC trainers. The Peer Support Program continues to provide quarterly Train the Trainer events to ensure that Washington's

CPC trainers have the skills they need to provide high quality training. The Peer Support Program is in process of creating fidelity tools for both CPC Trainings as well as CPC programs.

Since 2005, the Peer Support Program has certified 11,822 Certified Peer Counselors. In FY24, HCA sponsored 134 Certified Peer Counselor trainings with 2,091 people trained as Certified Peer Counselors.

Of the 2,091 people trained in FY24:

- 1,015 identify as either having substance use or co-occurring recovery
- 296 as youth and family peers

In SFY 2025, HCA is sponsoring 90 training courses and to date has trained a total of 1,437 certified peer counselors. Of the 1,437 people training in FY25:

- 665 of them identify as either having substance use or co-occurring recovery
- 184 as youth and family peers

HCA received a record number of applications in the past 2 years as interest has increased with the addition of the new profession of Certified Peer Support Specialist that launched July 1, 2025. HCA received 3,893 applications in 2024 and 3,995 applications in 2025.

In 2023, the Washington State legislature created the profession of certified peer specialists, a standalone credential for Peer Specialists through the Department of Health that went live July 1, 2025. Previously, peer counselors were credentialed under the umbrella of Agency Affiliated Counselors (AAC). This new profession created two tiers of Peer Specialists under the credential; a Certified Peer Specialist Trainee and a Certified Peer Specialist There will also be endorsement for an approved Supervisor for Certified Peer Specialist Trainees. The approved supervisor will be a certified peer counselor or a certified peer specialist who has completed specialized training and has completed joint supervision hours under a peer supervisor. HCA has been working in partnership with the Department of Health on topics related to the implementation of the bill.

The peer support program continues to collaborate with the Office of Insurance Commissioner and Managed Care Organizations on potential enhancement of peer services beyond Medicaid reimbursed settings.

Technical Assistance to Agencies

A technical assistance program was created called “Operationalizing Peer Support” (OPS). OPS provides evidence based technical and professional assistance to agencies with the implementation and operationalization of new and existing peer services. The program supports agencies and organizations through trainings, monthly webinars, a book club and weekly “Office Hours.” Training topics include Peer Services in Washinton state, training and credentialling, creating a recovery orientated and trauma informed environment, licensing as a behavioral health agency and Medicaid reimbursement, recruitment, onboarding, retention of peers, peer-oriented supervision, documentation, and ethics and boundaries. In FY24 HCA hosted 20 training courses and 18 in FY25, with 248 and 286 individuals trained respectfully. The Operationalizing Peer Support program hosted 16 webinars in the past two years.

Additional Workforce Continuing Education and Technical Assistance

HCA held the 10th Annual Peer Pathways Conference in August 2025. The conference presenters included national and local peer experts with lived experience in mental health and substance use recovery. The conference continues to grow and provide support to the peer community.

State Tribal Agreements and Contracts with Tribes

In the past two years, the HCA has been working to modify the Indian Nation Agreements. The original agreements with tribes through the Health Care Authority were established in 2019 through a consultation process. The new agreements were negotiated through consultation in April 2025, and the new Sovereign Nation Agreements (SNA) will be implemented 7/1/2025 that will pass down SUPTRS grants along with other federal and state dollars to tribes.

The SNA is an umbrella agreement that includes the general terms and conditions and includes multiple scopes of work for behavioral health service as needed. This SNA also includes the program agreement and scope of work for behavioral health services which includes several state and federal funding resources including the Substance Use Prevention, Treatment and Recovery Services Block Grant. Indian nations can braid various funding resources to support services that best meet the needs in tribal communities along the continuum of behavioral health including mental health promotion (using state funds only), prevention, treatment, 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 SNA using additional scopes of work. This also enables the tribes to focus funding on efforts that are most needed within their community, considering their unique needs and resources within each tribal government.

HCA plans to maintain the current level of regular Block Grant funding for tribes and identify additional funding resources so that Sovereign Indian Nations have the resources to expand their behavioral health programs as they feel necessary for their community.

Since 2019, HCA has expanded the number of direct funding projects and dollars to tribes with initially being about $3 million dollars to well over $20 million in direct funds to tribes. These funds honor our tribal government to government relationships and ensure tribes have access to behavioral health funding to continually expand their health services, not only providing services to tribal members and individuals that identify as native, but to all non-native community members for some tribes that are able to expand their services to non-tribal members.

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

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

- Support for various statewide conferences as outlined in the conference and training section.

- Support to the Tribal Opioid Task Force, subcontracted through the American Indian Health Commission which includes revamping the American Indian/Alaska Native Opioid Response Workgroup to be a subcommittee of the group along with a prevention, education and awareness tribal workgroup.

- Support for the tribal 988 subcommittee and the Tribal Centric Behavioral Health Advisory Board (TCBHAB) 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

- Native Resources Hub

- Implementation of the Washington Indian Behavioral Health Improvement Act

- Ombudsman and care coordination support for complex cases

- Support for 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.

- 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 (TIM) documentation and outcome measures report. Next year HCA will embark on submitting a TIM State Waiver to CMS as a demonstration project.

- 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 data 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.

- 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 Government-to-Government plans to other health care areas as prioritized by tribal governments and urban Indian organizations.

- Support hosting tribal specific Certified Peer Counseling training to further engage tribes in expanding their peer programs.

Tribal Behavioral Health Conferences, Workforce Development, And Trainings

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

- Training for all new Designated Crisis Responders (DCRs) attending the DCR Academy and Trueblood program implementation staff on government-to-government principle's, the Indian health care delivery system, and best practices for working with Tribes and AI/AN communities.
- Tribal Certified Peer Counselor trainings (6 in the past biennium and this will be ongoing using leveraged grants). Support for a state and tribal delegation to learn more about the prevention program, Planet Youth Icelandic model to identify best practices that can be implemented in Tribal communities.
- Support for a Tribal-State Opioid/Fentanyl Summit to convene tribal leaders and state elected officials to create solutions to address the fentanyl crisis for AI/AN individuals, families, and communities.
- Creation of training materials that the Indian Behavioral Health Hub will use to train all 988 crisis line staff and behavioral health aides on the Volunteers of America Western Washington, Native Resources Hub and Native and Strong Lifeline (Tribal 988) resources and best practices to working with tribal communities. Creation of training materials for IBHH staff and families on the Joel's Law petitions.
- Training on the prevention management information system, Minerva.

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 Behavioral Health Aides. Behavioral Health Aides are federally licensed by the Indian Health Services and can provide a variety of services including mental health and SUD treatment services, prevention, and crisis response support under the supervision of a licensed clinical professional. The HCA is looking to explore ways that BHA services can be fully funded by various funding streams such as by grants and Medicaid billing. In 2022 and 2023, HCA worked with these partners to create a State Plan Amendment to incorporate BHAs in the Medicaid State Plan. Tribal Consultation was held to review the new state plan in 2023.

Office of Recovery Partnership

The Office of Consumer Partnership (OCP) changed its name in 2020 to the Office of Community Voices and Empowerment (OCVE) to better reflect the specific purpose of this office. The office currently consists of one full-time senior administrator. The OCVE is a priority within HCA with a clearly defined purpose. Some key elements include:

- Advocates for behavioral health community voice and choice at every level of state government.
- Serves as a conduit for those who have lived/living experience with or who have been impacted by behavioral health challenges to work collectively to shape, inform and transform behavioral health systems in Washington State.
- Facilitates OCVE Advisory Committee comprised of lived/living experienced members from all regions of Washington state representing individuals, families, caregivers, providers, local and state government.
- Oversees agency wide recovery and wellness employee resource group that provides support, education and resources for agency staff.
- Provides statewide behavioral health education, resourcing, advocacy and leadership training across lifespan.
- Provides oversite for statewide behavioral health lived/living experienced speaker bureau.
- Assists in the development and support of emerging community leadership.
- Promotes wellness and recovery values agency and statewide

- Provides community outreach and engagement opportunities agency and statewide.

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

This narrative should describe your states needs assessment process to identify needs and service gaps for its population with mental or substance use disorders as well as gaps in the prevention system. A needs assessment is a systematic approach to identifying state needs and determining service capacity to address the needs of the population being served. A needs assessment can identify the strengths, and the challenges faced in meeting the service needs of those served. A needs assessment should be objective and include input from people using the services, program staff, and other key community stakeholders. Needs assessment results should be integrated as a part of the state's ongoing commitment to quality services and outcomes. The findings can support the ongoing strategic planning and ensure that its program designs and services are well suited to the populations it serves. Several tools and approaches are available for gathering input and data for a needs assessment. These include use of demographic and publicly available data, interviews, and focus groups to collect stakeholder input, as well as targeted and focused data collection using surveys and other measurement tools.

Please describe how your state conducts needs assessments to identify behavioral health needs, determine adequacy of current services, and identify key gaps and challenges in the delivery of quality care and prevention services.

Grantees must describe the unmet service needs and critical gaps in the state's current systems identified during the needs assessment described above. The unmet needs and critical gaps of required populations relevant to each Block Grant within the state's behavioral health system, including for other populations identified by the state as a priority should be discussed. Grantees should take a data-driven approach in identifying and describing these unmet needs and gaps.

*Data driven approaches may include utilizing data that is available through a number of different sources such as the **National Survey on Drug Use and Health (NSDUH)**, **Treatment Episode Data Set (TEDS)**, **National Substance Use and Mental Health Services Survey (N-SUMHSS)**, the **Behavioral Health Barometer**, **Behavioral Risk Factor Surveillance System (BRFSS)**, **Youth Risk Behavior Surveillance System (YRBSS)**, the CDC mortality data, and state data. Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention, treatment, and recovery support services planning. States with current Strategic Prevention Framework - Partnerships for Success discretionary grants are required to have an active SEOW.*

This step must also describe how the state plans to address the unmet service needs and gaps identified in the needs assessment. These plans should reflect specific services and activities allowable under the respective Block Grants. In describing services and activities, grantees must also discuss their plan for implementation of these services and activities. Special attention should be made in ensuring each of the required priority populations listed above, and any other populations, prioritized by the state as part of their Block Grant services and activities are addressed in these implementation plans.

WASHINGTON STATE NEEDS ASSESSMENT

Please describe how your state conducts statewide needs assessments to identify needs for mental and substance use disorders, determine adequacy of current services, and identify key gaps and challenges in the delivery of quality care and prevention services.

Washington state utilizes two primary data systems for treatment data including supplemental and encounters for the state mental health and substance use disorder integrated Behavioral Health Data System (BHDS) and Provider One (claims-based data system). HCA is in the process of transitioning some data collection off of old systems including our TARGET data system still heavily utilized by tribes and problem gambling reporting in our state. In 2024 the legislature funded a cross-agency effort to improve and streamline behavioral health data collection and reporting.

This would include continued efforts to identify a solution to move tribes from TARGET to our existing data platforms to streamline, consolidate, and improve the quality of data collected by tribes and Urban Indian Health Plans.

To make data-informed needs assessments with planning, policy development, service provision, and reporting DBHR continues to integrate stakeholder and community input, including input from the Mental Health Block Grant required planning council which in Washington is an integrated council advising on both Substance Use Disorder, and problem gambling, in addition to mental health services. The **Behavioral Health Advisory Council**

provides HCA with valuable information on system needs and gaps from the lens of those with lived system experience, providers, families, tribes, state agency partners, etc.

DBHR also utilizes an independent peer review process that matches credentialed providers with like credentialed facilities to review and provide information on treatment practices, needs, and gaps, or innovative practices. 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 serves as the primary data workgroup for the **Washington State Prevention Enhancement (SPE) Policy Consortium's State Substance Abuse Prevention and Mental Health Promotion Five-Year Strategic Plan**. Using a data-based approach, the 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.

DBHR's Recovery Support Services utilizes the **Peer Support Advisory Group** to inform HCA of needs and gaps around training and certifying peers. Some of these topics include increasing the amount of HCA approved trainers and training organizations and updating and creating curriculum that meets the needs of the peer workforce.

HCA supports the **American Indian/Alaska Native Opioid Response workgroup**, in partnership with the American Indian Health Commission. This workgroup discusses successes, strengths, and gaps within the system to address the opioid crisis. The HCA has partnered with state agencies tribal liaisons to develop a plan to improve tribal engagement and data accessibility for tribal health and school partners.

DBHR utilizes local reports that indicate need and usage of the inpatient, **Involuntary Treatment Act (ITA), and crisis systems**. This information informs planning to address gaps in inpatient, crisis, and diversion capacity and also informs the work that DBHR is doing to shift long term involuntary treatment from the state psychiatric hospitals to contracted community settings.

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, is used by DBHR to estimate prevalence rates at state, county, school districts, and school building levels.

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 Young Adult Health Survey (YAHS)**. NSDUH is used to estimate and monitor substance use prevalence rates. BRFSS provides information to identify needs and gaps. The YAHS measures cannabis and other substance use, perceptions of harm, risk factors, and consequences among young adults (18 to 25 years old) living in Washington State.

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 targeting 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.

Priority populations focused on include:

- Pregnant Women and Women with Dependent Children (PWWDC)
- Persons Who Inject Drugs (PWID)
- Persons in Need of Recovery Support Services for SUD (PRSUD)
- Individuals with a Co-occurring Mental Health and SUD
- Persons Experiencing Homelessness
- Persons with SUD at Risk for Tuberculosis (TB)
- Individuals diagnosed with a Serious Emotional Disturbance (SED)
- Individuals diagnosed with a Serious Mental Illness (SMI)

Mental health resource allocation will continue to be based on prevalence and treatment needs. Individuals diagnosed with Serious Mental Illness or a Serious Emotional Disturbance that do not qualify for treatment services through Medicaid or other insurance will be prioritized through the Mental Health Block Grant.

Substance Use Disorder treatment is largely paid for through Medicaid expansion. State General Funds and discretionary/formulary grants are used to pilot innovative programs. For non-Medicaid services, we collect data, analyze outcomes, and evaluate ongoing funding. Individuals without Medicaid or other insurance will be prioritized for treatment services using SUPTRS Block Grant funding for specific priority populations.

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 risk based on CORE GIS data. CPWI is unique in its approach to community selection because CPWI uses a data-informed community selection process.

Strategy to Identify Unmet Needs and Gaps

Please describe the unmet service needs and critical gaps in the state's current mental and substance use systems identified in the needs assessment described above. The description should include the unmet needs and critical gaps for the required populations specified under the MHBG and SUPTRS BG "Populations Served" above. The state may also include the unmet needs and gaps for other populations identified by the state as a priority.

Gap 1

Gap: Access to critical services through outpatient, inpatient, and withdrawal management needs to be improved for individuals with a substance use disorder or co-occurring disorder.

- Washington state has many rural and frontier counties with significant distances between providers, particularly specialty providers for those facing the greatest need.
- The continued strain on the behavioral health workforce remains a barrier that is exacerbated by Washington's landscape of rural and frontier communities.
- A significant state deficit and the ending of COVID-era behavioral health funding support, while the need is still high, has resulted in services being reduced across the state.

Populations effected include: Pregnant Women and Women with Dependent Children (PWWDC), Persons who Inject Drugs (PWID), Persons with SUD at Risk for Tuberculosis (TB), Persons Experiencing Homelessness, Individuals with a co-occurring MH and SUD

Gap 2

Gap: Providers in the Parent Child Assistance Program (PCAP) do not have the resources and supports needed to ensure they can continue to provide PCAP.

- One of the gaps Washington has noted for the PCAP population is in integrated family care and services, a model that preserves the family support system of both parents while providing treatment services when both have substance abuse treatment needs.
- The continued strain on the behavioral health workforce remains a barrier, particularly in Washington's rural and frontier communities.
- Reimbursement rates for PCAP services remain a challenge noted by providers.
- The stigma facing pregnant and parenting women remains a barrier to ensuring the populations who need services are successfully engaged.

Populations effected include: Pregnant Women and Women with Dependent Children (PWWDC)

Gap 3

Gap: The number of active mobile crisis teams should be increased to meet statewide need.

Populations effected include: Serious Mental Illness (SMI), Serious Emotional Disturbances (SED), Early Serious Mental Illness (ESMI), Behavioral Health Crisis Services (BHCS), Pregnant Women and Women with Dependent Children (PWWDC), Persons who Inject Drugs (PWID), Tuberculosis (TB), Persons in need of recovery support services from SUD (PRSUD), Individuals with a co-occurring MH and SUD

Gap 4

Gap: The need for opioid use disorder treatment is greater than the volume of services currently provided, particularly for current or recently incarcerated individuals.

Populations effected include: Pregnant Women and Women with Dependent Children (PWWDC), Persons who Inject Drugs (PWID), Tuberculosis (TB), Persons in need of recovery support services from SUD (PRSUD), Individuals with a co-occurring MH and SUD

Gap 5

Gap: The number of providers who offer first episode psychosis (FEP) services, is projected to decrease, while the estimated number of individuals needing these services is expected to remain the same.

Populations effected include: Serious Mental Illness (SMI), Serious Emotional Disturbances (SED), Early Serious Mental Illness (ESMI), Behavioral Health Crisis Services (BHCS), Individuals with a co-occurring MH and SUD

Strategy to Align Behavioral Health Funding with Unmet Needs and Gaps

Please describe how the state plans to address the unmet service needs and gaps identified in the needs assessment. These plans should reflect specific services and activities allowable under the respective Block Grants. In describing services and activities, grantees must also discuss plans for the implementation of these services and activities. Special attention should be made in ensuring each of the required priority populations and any other populations prioritized by the state as part of the Block Grant services and activities are addressed in the implementation plan.

Gap 1

Gap: Access to critical services for individuals with a substance use disorder or co-occurring disorder

Populations effected include: Pregnant Women and Women with Dependent Children (PWWDC), Persons who Inject Drugs (PWID), Persons with SUD at Risk for Tuberculosis (TB), Persons Experiencing Homelessness, Individuals with a co-occurring MH and SUD

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

Washington plans to increase the treatment initiation and engagement rates among the number of youth and adults accessing substance use treatment outpatient services, including

adults who receive medications for the treatment of opioid use disorder (e.g. Methadone, Buprenorphine, and/or Naltrexone). HCA will continue to work with behavioral health providers to explore new mechanisms and protocols for case management and continue to use performance-based contracts to ensure the focus remains on increasing the number of individuals receiving SUD and MOUD services.

Data Needs: Behavioral health provider mapping efforts to identify current adolescent network and identify access challenges and strategies to remove system barriers.

The primary data needed to assess progress on this gap is treatment rates for both MH and SUD services. Washington produces these on a quarterly basis.

Responsible Parties: The Health Care Authority will work with the Behavioral Health Administrative Organizations (BH-ASOs) and Managed Care Organizations (MCOs) to ensure focus and oversight of the provider network.

Timeline Estimates: Over the next two years Washington has a goal of a 5% increase in the treatment initiation and engagement rates among the number adults accessing substance use treatment outpatient services, including adults who receive medications for the treatment of opioid use disorder (e.g. Methadone, Buprenorphine, and/or Naltrexone). For youth receiving services, Washington will continue to assess all opportunities to increase the treatment initiation and engagement rates and currently has a goal of maintaining current levels.

Anticipated/Potential Difficulties:

- A significant state funding deficit and the ending of several federal supplemental awards and behavioral health funding support, while treatment needs remain high, has resulted in services being reduced across the state, thereby reducing access to those services.
- Washington state has many rural and frontier counties with significant distances between providers, particularly specialty providers for those facing the greatest need.
- The continued strain on the behavioral health workforce remains a barrier that is exacerbated by Washington's landscape of rural and frontier communities and the funding deficit.

Gap 2

Gap: Behavioral Health providers who deliver services as part of the Parent Child Assistance Program (PCAP) do not have the resources and supports needed to ensure they can continue to provide PCAP.

Populations effected include: Pregnant Women and Women with Dependent Children (PWWDC),

Objective: Pregnant and parenting individuals continue to be a priority population for substance use disorder services to improve their health and assist in maintaining recovery. Our objective is to increase provider site stability to provide further services via the Parent Child Assistance Program (PCAP) and improve the health of pregnant women and their children with a substance use disorder.

Data Needs: Provider stability will be assessed by tracking capacity and enrollment, specifically the number of individuals receiving PCAP services.

Responsible Parties: The Health Care Authority will continue working closely with PCAP providers to understand program capacity and workforce stabilization needs. Data will continue to be monitored via reports provided through the University of Washington on individuals being served.

Timeline Estimates: Over the next two years Washington aims to maintain the current level of services to PCAP providers while assessing our capacity, funding, and enrollment to identify barriers that can be reduced to increase access to services.

Anticipated/Potential Difficulties: State funding for PCAP programs was recently reduced, resulting in sites being unable to expand services. Some of the sites do not have enough workforce to support the increased need for services, or facility space to support increased staffing needs. This is enhanced by a significant state funding deficit and the ending of Federal COVID era behavioral health funding support, while treatment needs remain high, has resulted in services being reduced across the state, thereby reducing access to those services.

Gap 3

Gap: The number of active mobile crisis teams is not sufficient to meet statewide need.

Populations effected include: Serious Mental Illness (SMI), Serious Emotional Disturbances (SED), Early Serious Mental Illness (ESMI), Behavioral Health Crisis Services (BHCS), Pregnant Women and Women with Dependent Children (PWWDC), Persons who Inject Drugs (PWID), Tuberculosis (TB), Persons in need of recovery support services from SUD (PRSUD), Individuals with a co-occurring MH and SUD

Objective: HCA will increase access to crisis services across the state and will reduce the burden on local law enforcement departments by providing an increased number of mobile crisis services that do not require co-response as well as ongoing stabilization services.

Data Needs: Total number of active mobile crisis teams statewide, as collected by the Behavioral Health Administrative Service Organizations (BHASO).

Responsible Parties: The Health Care Authority will continue working with mobile crisis teams to expand access to services and engage in target conversations with tribes for further expansion with tribal communities.

Timeline Estimates: Over the next two years Washington plans to add at least 2 new mobile crisis providers to address the state crisis needs.

Anticipated/Potential Difficulties: It can be difficult to predict the demand for new and emerging services. A significant state funding deficit and the ending of Federal COVID-era behavioral health funding support, while treatment needs remain high, makes funding an increase of mobile crisis teams difficult. The rural geography of our state makes positioning teams challenging to ensure that the needs of rural populations are fully realized.

Gap 4

Gap: The need for opioid use disorder treatment is greater than the volume of services currently provided, particularly within the population of individuals who are currently or were recently incarcerated.

Populations effected include: Pregnant Women and Women with Dependent Children (PWWDC), Persons who Inject Drugs (PWID), Tuberculosis (TB), Persons in need of recovery support services from SUD (PRSUD), Individuals with a co-occurring MH and SUD

Objective: HCA is committed to increasing the accessibility of treatment for individuals experiencing opioid use disorder, support individuals in recovery from opioid use disorder and reduce the harms associated with opioid use and misuse. Our goal is to increase opportunities for incarcerated individuals to receive OUD assessment, OUD medication, sustained treatment throughout incarceration, and connection to continue treatment upon release or transfer.

Data Needs: The OUD treatment rate statewide as well as the volume of treatment services provide through MOUD in jail programs.

Responsible Parties: The Health Care Authority will continue working with jail programs throughout the state.

Timeline Estimates: With the funding from Washington's opioid abatement account in addition to federal funding supports for addressing the opioid crisis Washington aims to increase the number of individuals receiving services in 2026 by at least 700.

Anticipated/Potential Difficulties: Workforce availability and stigma surrounding evidence-based treatments for MOUD, particularly those involved in the criminal legal system.

Gap 5

Gap: The number of providers who offer first episode psychosis (FEP) services, is projected to decrease, while the estimated number of individuals needing these services is expected to remain the same.

Populations effected include: Serious Mental Illness (SMI), Serious Emotional Disturbances (SED), Early Serious Mental Illness (ESMI), Behavioral Health Crisis Services (BHCS), Individuals with a co-occurring MH and SUD

Objective: Ensure that the total capacity of mental health community-based agencies who serve youth diagnosed with First Episode Psychosis remains constant statewide.

Data Needs: Number of individuals who receive FEP services, collected through URS tables via reporting from Washington State University.

Responsible Parties: The Health Care Authority will continue work with New Journeys sites to support the needs of communities and sustain access to FEP services.

Timeline Estimates: Work will be ongoing in Washington state to make sure that we can meet the needs of this priority population while also working closely with providers to support their needs to ensure they can continue providing services.

Anticipated/Potential Difficulties: Expansion of coordinated specialty care for first episode psychosis has slowed due to reductions in state funding. Sites are also struggling to expand access due to clinician turnover and primary care and behavioral health workforce shortages.

Prioritize State Planning Activities

Development of Goals, Objectives, Performance Indicators and Strategies

Table 1: Priority Areas and Annual Performance Indicators

Priority # 1 – Tribes

Priority Area: Collaborate with Washington State tribal governments, in a government-to-government manner implementing substance use disorder (SUD) prevention, treatment and recovery programs as they see fit, to address high disproportionate rates of SUD, overdoses and mental health (MH) disorders amongst American Indian and Alaska Native (AI/AN) individuals in WA state.

Priority Type: SUP- Substance Use Prevention, SUT - Substance Use Disorder Treatment, SUR - Substance Use Recovery, BHCS – Behavioral Health Crisis Services

Population(s): Behavioral Health Crisis Services (BHCS), American Indian/Alaska Native individuals who are Pregnant Women and Women with Dependent Children (PWWDC), AI/AN Persons who Inject Drugs (PWID), AI/AN individuals with Tuberculosis (TB), AI/AN Persons in need of substance use primary prevention (PP), AI/AN Persons in need of recovery support services from SUD (PRSUD)

Goal of the priority area:
The goal of this priority is to establish a government-to-government agreement with the tribes 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 SUPTRS dollars.
The Health Care Authority follows the RCW 43.376 and a communication and consultation policy which outlines the state regulations for Government-to-Government 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 Use Prevention, Treatment and Recovery Support Services Block Grant funding to help bolster prevention, treatment, overdose and recovery support services within their tribal communities.

Objective: Support to tribes to leverage these funding resources to prioritize their strategies as appropriate to their community to ensure appropriate care and the sovereign right for the tribes to decide how best to utilize these funds and tailor programs within their community.

- Work with each individual tribe to address specific needs to support prevention, treatment and recovery services for individuals with substance use disorder.
- Prevention: Support to the tribes to use block grant funding to begin and/or maintain tribal substance use disorder community-based prevention programs and projects for youth within tribal communities.
- Treatment: Support to the tribes to use block grant and other funding resources for the treatment and overdose intervention services for youth and adults who are non-insured or underinsured for treatment services. These services may include, case management, drug screening tests including urinary analysis, treatment support services (transportation, childcare), outpatient and intensive outpatient, and individual and group therapy, and naloxone distribution.
- Recovery Support: Support to the tribes to use block grant funding to develop and enhance their recovery support services programs for any non-Medicaid billable services or support to individuals who are non-insured or underinsured.
- Opioid Response: Support to the tribes to use block grant funding to address opioid overdose and opioid use disorders in their community by delivering either OUD prevention, treatment, and recovery support services.

Strategies to attain the objective:

- Each tribe is requested to complete an annual tribal plan and budget that indicates how the funding will be expended for the delivery of SUD prevention, 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 services to American Indian/Alaska Natives.

Baseline Measurement: SUD Prevention – 39,373 total unduplicated and duplicate participants served by direct tribal prevention services provided during SFY24 (July 1, 2023 – June 30, 2024)

First-year target/outcome measurement: SFY26 (July 1, 2025 – June 30, 2026) SUD Prevention – Increase or maintain 51,714 total unduplicated and duplicate participants in direct services prevention programs

Second-year target/outcome measurement: SFY27 (July 1, 2026 – June 30, 2027) SUD Prevention – Increase or maintain 51,714 total unduplicated and duplicate 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 SUBG prevention performance indicators.

Description of Data:
As reported into Minerva by tribes, total number of AI/AN clients served between July 1, 2023, and June 30, 2024.

Data issues/caveats that affect outcome measures:

- Indian Health Care Providers must enter data into multiple systems in their work to improve health information technology in their programs which is burdensome. Tribes are working to move to electronic health records, 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.
- SUD Prevention numbers may include duplication of client counts due to tribes reporting number of people in attendance at events for each day.

Indicator #: 2

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

Baseline Measurement: SUD Treatment outpatient services - Individuals Served: 4,578 during SFY24 (July 1, 2023 – June 30, 2024)

First-year target/outcome measurement: SFY26 (July 1, 2025 – June 30, 2026) SUD Treatment outpatient services - Individuals Served: 3,355

Second-year target/outcome measurement: SFY27 (July 1, 2026 – June 30, 2027) SUD Treatment outpatient services- Individuals Served: 3,355

Data Source:
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, 2023, and June 30, 2024.

Data issues/caveats that affect outcome measures:

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

Indicator #: 3

Indicator: Maintain Opioid Treatment Programs providing services to American Indian/Alaska Natives

Baseline Measurement: Opioid Treatment Programs (OTPs) within tribes: Ten OTPs, zero fixed site mini opioid treatment medication units and nine mobile units within tribes for SFY24 (July 1, 2023 – June 30, 2024)

First-year target/outcome measurement: SFY26 (July 1, 2025 – June 30, 2026) SUD MOUD – Increase tribal MOUD and OTPs to a total of eleven OTPs, one fixed site mini opioid treatment medication unit and ten mobile units available in tribal and non-tribal communities.

Second-year target/outcome measurement: SFY27 (July 1, 2026 – June 30, 2027) SUD MOUD – Increase tribal MOUD and OTPs to a total of twelve OTPs, two fixed site mini opioid treatment medication unit and eleven mobile units available in tribal and non-tribal communities.

Data Source:
State Opioid Authority

Description of Data:
Number of Opioid Treatment Programs within tribes

Data issues/caveats that affect outcome measures:

- Indian Health Care Providers must enter data into multiple systems in their work to improve health information technology in their programs which is burdensome. Tribes are working to move to EHRs, are using an Indian Health Services System, plus the state data systems which are often duplicative and can be expensive to dedicate additional staff to enter data into multiple systems.

Indicator #: 4

Indicator: Develop tribal action plans with each tribe to utilize block grant funds to fill gaps in services to expand their existing SUD prevention, treatment, and recovery support services for their communities.

Baseline Measurement: 28 tribal plans completed with tribal governments for SFY25

First-year target/outcome measurement: SFY26 (July 1, 2025 – June 30, 2026) Maintain number of tribal plans completed with at least 28 tribal governments for SFY26

Second-year target/outcome measurement: SFY27 (July 1, 2026 – June 30, 2027) Maintain number of tribal plans completed with at least 28 tribal governments for SFY27

Data Source:

Government to Government tribal agreements.

Description of Data:
Government to Government tribal action plans on file.

Data issues/caveats that affect outcome measures:
None

Priority # 2 – Prevention

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

Priority Type: Substance Use Prevention (SUP)

Population(s): Persons in need of substance use primary prevention (PP)

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

Objectives:

- Decrease the percentage of 10th graders who report using alcohol in the last 30 days.
- Prevent the increase in the percentage of 10th graders who report using cannabis in the last 30 days.
- Decrease the percentage of 10th graders who report using tobacco and vape products in the last 30 days.
- Decrease the percentage of 10th graders who report misusing/abusing painkillers in the past 30 days.
- Decrease the percentage of young adults who report using non-medical marijuana (cannabis).
- Decrease the percentage of young adults who report using alcohol in the last 30 days.

Item	2018	2021	2023	Target set in 2021; next update 2027
Alcohol 30-day use	18.5%	8.4%	9.1%	14.0%
Cannabis 30-day use	17.9%	7.2%	8.4%	9.0%

Tobacco 30-day use (excludes vape products)	7.9%	2.1%	4.4%	7.1%
Vape 30-day use	21.2%	7.6%	7.7%	19.1%
Painkiller in past 30 days to get high	3.6%	1.0%	1.6%	1.5%
Young adults non-medical cannabis past year	48.5%	51.2%	46.2%	48.5%
Young adult alcohol 30-day use	61.1%	56.9%	53.8%	51.2%

Note on Targets:
Targets were originally set in 2021; however, they are based on pre-pandemic 2018 Healthy Youth Survey (HYS) outcomes. The COVID-19 pandemic necessitated methodologic changes in data collection for surveys administered since 2020 including the HYS and the National Survey on Drug Use and Health (NSDUH). Due to these changes, we retained the targets based on 2018 data until we can verify new trends post-pandemic. We have included the 2021 and 2023 rates, which were both administered fully online, for surveillance. This will provide more complete information as we continue monitoring trends to separate the impact of methodologic changes from true changes in the outcomes. The targets for each item will be updated as part of the 2027 revision to the Washington State Substance Use Disorder Prevention and Mental Health Promotion Five-Year Strategic Plan.

As with previous target updates, the goal was to have 5% reductions in two-to-three years and 10% reductions in four-to-five years. Targets set for 2023 reflect previous target setting measures. For HYS 2021 pandemic-era data, statements were included to acknowledge the substantially different results and identify general directional targets.

Strategies to attain the objective:

- Implement performance-based contracting with each prevention contractor.
- Adapt programs to address the unique needs of each tribe or community.
- Strategies to serve AI/AN communities with increased risk for SUD concerns through various prevention projects using leveraged resources.
- Deliver Evidence-based and Evidence-informed Prevention Programs and Strategies (EBPs) according to approved strategic plans.
- Refine definitions and processes for identifying EBPs to ensure EBPs are backed by sound theory and evidence.
- Deliver direct prevention services (All CSAP Strategies).
- Deliver community-based prevention services (Community-based process, Information Dissemination and Environmental strategies).
- Disseminate state level public education campaigns with toolkits for localized implementation.
- Provide statewide Workforce Development Training to build capacity for service delivery.
-
- Maintain and increase direct service programs for young adults.

- Identify relevant risk/protective factors for young adult substance use, inventory available programs, and integrate review processes to identify EBPs for young adult populations.

Annual Performance Indicators to Measure Goal Success

Indicator #: 1

Indicator: Reduce substance use/misuse

Baseline Measurement: Average of 13,596 unduplicated participants including coalition members and partners served by direct services provided during SFY 2024 (July 1, 2023 – June 30, 2024)

First-year target/outcome measurement: Maintain a minimum of 12,662 unduplicated participants in direct services prevention programs. SFY2026 – 7/1/2025-6/30/2026

Second-year target/outcome measurement: Maintain a minimum of 12,662 unduplicated participants in direct services prevention programs. SFY2027 - 7/1/2026-6/30/2027
Note: Targets are reduced from the baseline to account for reduced funding.

Data Source:
Minerva - SUD Prevention and MH Promotion Online Reporting System (Washington's Prevention Management Information Service): used to report SUPTRS 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 annually.

Description of Data:
SUPTRS performance indicators are used to measure Center for Substance Abuse Prevention Strategies and Institute of Medicine Categories for services provided annually. From the Washington State Healthy Youth Survey (HYS), 10th grade substance use among Washington youth is used to measure intermediate outcomes. From the 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:
Washington State transitioned prevention reporting system vendors in Fall 2021. Since that time, the system has been fully implemented and is now used statewide for all prevention data collection and reporting. Data integrity may still be affected by factors such as staff turnover, variation in provider capacity, and inconsistent interpretation of reporting guidance. DBHR continues to provide ongoing training, technical assistance, and system enhancements to support accurate, timely, and complete data entry. These efforts aim to minimize gaps or inconsistencies.

Priority # 3 – SUD Treatment Services

Priority Area: Increase the number of individuals receiving outpatient substance use disorder treatment

Priority Type: Substance Use Treatment (SUT)

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

Goal of the priority area:
Increase the treatment initiation and engagement rates among the number of youth and adults accessing substance use treatment outpatient services, including adults who receive medications for the treatment of opioid use disorder (e.g. Methadone, Buprenorphine, and/or Naltrexone).

Objective:

- Require Behavioral Health Administrative Service Organizations (BH-ASOs) and Managed Care Organizations (MCOs) to continue to maintain behavioral health provider network adequacy for adolescents and adults.
- Improve access and increase available SUT outpatient services for youths and adults.

Strategies to attain the objective:

- Conduct behavioral health provider mapping efforts to identify current adolescent network. Identify access challenges and strategies to remove system barriers.
- Continue using performance-based contracts with BH-ASOs and MCOs to ensure focus and oversight of provider network.
- Continue efforts to actively engage youth in a co-design project to begin reimagining a better continuum of care for youth and young people with SUT needs.
- Explore new mechanisms and protocols for case management and continue using performance-based contracts to increase the number of adults receiving outpatient SUD and MOUD services.

Annual Performance Indicators to Measure Goal Success

Indicator #: 1

Indicator: Increase youth outpatient SUD treatment services

Baseline Measurement: During SFY24 (July 1, 2023 – June 30, 2024) 1,880 of Apple-Health enrolled youth received SUD treatment services.

First-year target/outcome measurement: Increase the number of Apple-Health enrolled youths receiving SUD outpatient treatment services in SFY26 (July 1, 2025 – June 30, 2026) to 1,800

Second-year target/outcome measurement: Maintain the number of youths receiving SUD outpatient treatment services in SFY27 (July 1, 2026 – June 30, 2027) to 1,800

Data Source:
The number of youth receiving SUD outpatient services provided is tracked using the Behavioral Health Data System (BHDS). Additional context regarding treatment need has also been assessed through the Behavioral health access and network adequacy for Apple Health children and youth (prenatal – age 25).

Description of Data:
The calendar year 2024 data is an unduplicated count of youth (persons under 18 years of age) served in publicly funded SUD outpatient treatment.

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.

Indicator #: 2

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

Baseline Measurement: SFY24: 45,046 individuals received SUD and MOUD treatment services.

First-year target/outcome measurement: Increase the number of individuals receiving outpatient SUD treatment and MOUD services at an Opioid Treatment Program in SFY26 to 47,298, which would be a 5% Increase.

Second-year target/outcome measurement: Increase the number of individuals receiving outpatient SUD treatment and MOUD services at an Opioid Treatment Program in SFY27 to 49,662, which would be a 5% increase from SFY26 target.

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

Description of Data:

Fiscal Year 2024 is an unduplicated count of adults (persons 18 years of age and older) served in publicly funded SUD outpatient treatment and/or receiving MOUD between July 1, 2023, and June 30, 2024.

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 # 4 – Mental Health Treatment Services

Priority Area: Maintain outpatient mental health services for youth with Serious Emotional Disturbance (SED) and adults diagnosed with Serious Mental Illness (SMI)

Priority Type: Mental Health Services (MHS), Early Serious Mental Illness (ESMI), Behavioral Health Crisis Services (BHCS)

Population(s): Severe Emotional Disturbances (SED), Serious Mental Illness (SMI), Behavioral Health Crisis Services (BHCS), Early Serious Mental Illness (ESMI)

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

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

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

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Maintain outpatient Mental Health services to youth diagnosed with Serious Emotional Disturbance (SED)

Baseline Measurement: SFY24: 85,954 youth with SED received services

First-year target/outcome measurement: Maintain the number of youths with SED receiving outpatient services to at least 76,000 in SFY26

Second-year target/outcome measurement: Maintain the number of youths with SED receiving outpatient services to at least 76,000 in SFY27

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 2024 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, 2023, through June 30, 2024.

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

Indicator #: 2

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

Baseline Measurement: SFY24: 241,201 adults with Serious Mental Illness (SMI) received mental health outpatient services

First-year target/outcome measurement: A minimum of 200,000 adults with Serious Mental Illness (SMI) receiving mental health outpatient services in SFY26 (we anticipate a decrease in numbers, bringing us closer to our normal baseline pre-Covid)

Second-year target/outcome measurement: A minimum of 200,000 adults with Serious Mental Illness (SMI) receiving mental health outpatient services in SFY27 (we anticipate a decrease in numbers, bringing us closer to our normal baseline pre-Covid)

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

Description of Data:

Fiscal Year 2024 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, 2023, and June 30, 2024.

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 # 5 – First Episode Psychosis

Priority Area: Maintain reasonable capacity for early identification and intervention for individuals experiencing First Episode Psychosis (FEP). We anticipate a potential reduction in sites in the next year due to loss in funding and are working to ensure services are maintained across the state.

Priority Type: Mental Health Services (MHS), Early Serious Mental Illness (ESMI)

Population(s): Serious Emotional Disturbance/Serious Mental Illness/Early Serious Mental Illness (SED/SMI/ESMI)

Goal of the priority area:
The primary goal is to maintain community based behavioral health services to Transition Age Youth who are diagnosed with First Episode Psychosis (FEP).

Objective:

- Maintain reasonable capacity in the community to serve youth experiencing First Episode Psychosis (FEP) through the New Journeys Program, while adjusting for potential site closures.

Strategies to attain the objective:

- Provide funding to maintain or expand the number of agencies who serve youth with First Episode Psychosis (FEP)
- Support mental health community based behavioral health services for youth diagnosed with First Episode Psychosis (FEP)
- New Journeys teams are currently working to adjust evidence-based recovery supports to better meet the needs of communities to sustain access to FEP services

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Maintain outpatient MH capacity for youth with First Episode Psychosis (FEP).

Baseline Measurement: SFY24: 16 First Episode Psychosis (FEP) Programs, serving a total of 287 youth

First-year target/outcome measurement: SFY26 (July 1, 2025 – June 30, 2026) Maintain the number of anticipated coordinated specialty care sites to 15 (we anticipate one site closing due to loss in funding) while maintaining services to a total of 280 youth statewide.

Second-year target/outcome measurement: SFY27 (July 1, 2026 – June 30, 2027) Maintain the 15 coordinated specialty care sites with a total of 280 youth served statewide.

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 # 6 – Recovery Support Services

Priority Area: Increase the number of behavioral health Certified Peer Support Specialist

Priority Type: Substance Use Recovery (SUR)

Population(s): PRSUD – Persons in need of recovery support services from SUD

Goal of the priority area:
Increase the number of behavioral health Certified Peer Support Specialists working in the field.

Objective:
- Pilot new Certified Peer Support Specialist trainings
- Develop a strategic plan to review curriculum, funding strategies and rule changes

Strategies to attain the objective:
- Identify any curriculum adjustments needed to integrate behavioral health peer services
- Strategic planning to incorporate behavioral health peer services into the system of care, exploring funding strategies and rule changes
- Increase recruitment of behavioral health Certified Peer Support Specialists and increase variety of training organizations.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Behavioral health Peer Support Specialist program

Baseline Measurement: From July 1, 2023 – June 30, 2024, total number of behavioral health Peer Support Specialist trained was 796

First-year target/outcome measurement: 1,100 Peer Support Specialists trained in SFY26

Second-year target/outcome measurement: 1,100 Peer Support Specialists trained in SFY27

Data Source:
Monthly reports obtained from the DBHR Peer Support Database

Description of Data:
Excel reports indicating the number of individuals trained by the HCA Peer Support program.

Data issues/caveats that affect outcome measures:
The number of trainings that HCA can fund for SFY26 and beyond are going to be less than SFY24 and SFY25. This reduction is an impact of new legislation requiring the training to increase from 40 hours to 80 hours, resulting in training costs increasing to almost double the 40-hour training.

Priority # 7 – Crisis Services

Priority Area: Increasing access to Behavioral Health Crisis Services (BHCS) through expansion of voluntary mobile crisis services.

Priority Type: Behavioral Health Crisis Services (BHCS), Substance Use Treatment (SUT), Substance Use Recovery (SUR), Mental Health Services (MHS)

Population(s): Serious Mental Illness (SMI), Serious Emotional Disturbances (SED), Early Serious Mental Illness (ESMI), Behavioral Health Crisis Services (BHCS), Pregnant Women and Women with Dependent Children (PWWDC), Persons who Inject Drugs (PWID), Tuberculosis (TB), Persons in need of recovery support services from SUD (PRSUD)

Goal of the priority area: Increase access to BHCS and improve outcomes for people receiving these services by expanding mobile crisis services. With the designation and routing of 988, the

State of Washington has been implementing SAMHSA's best practice toolkit with a focus on expanding mobile crisis services. This started in 2021 with new legislation and funding for more mobile crisis services. These efforts are ongoing.

Objective:

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

Strategies to attain the objective:

- Increase the number of mobile crisis teams
- Increase access to stabilization services by improving capacity of teams to provide these services
- Engage in targeted conversations with tribes for expansion of Mobile Crisis Teams within tribal communities

Annual Performance Indicators to Measure Goal Success

Indicator #: 1

Indicator: Maintain and increase number of mobile crisis providers in the state.
Baseline Measurement: 58 mobile crisis teams statewide during SFY25 (July 1, 2024 – June 30, 2025)

First-year target/outcome measurement: Maintain current statewide number of mobile crisis providers at 58 teams.

Second-year target/outcome measurement: Increase the statewide number of mobile crisis providers by at least 2 new teams, for a total of 60 teams statewide.

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

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

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

Priority # 8 – Pregnant and Parenting Women

Priority Area: Pregnant and Parenting Women with dependent Children

Priority Type: Substance Use Treatment (SUT)

Population(s): Pregnant women and women with dependent children receiving SUD services (PWWDC)

Goal of the priority area:
Support Parent-Child Assistance Program (PCAP) providers site stability and success by maintaining current total number of Pregnant and Parenting Women (PWWDC) clients receiving case management services.

Objective:
Continue providing PCAP services and improving the health of pregnant and parenting women and their children, with a focus on substance use recovery.

Strategies to attain the objective:

- Uphold current access levels to case management services while supporting provider stability.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Maintain capacity for women and their children to have access to case management services.

Baseline Measurement: SFY 2025, the total contracted number of Pregnant and Parenting Women (PWWDC) clients receiving PCAP case management services is 1,503.

First-year target/outcome measurement: SFY 2026 - Maintain the number of Pregnant and Parenting Women (PWWDC) clients receiving PCAP case management services at 1,503

Second-year target/outcome measurement: SFY 202**7** - Maintain the number of Pregnant and Parenting Women (PWWDC) clients receiving PCAP case management services at 1,503.

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 Washington ADAI for monthly reporting.

Data issues/caveats that affect outcome measures:
If funding is reduced for any reason, the number of sites/clients served may decrease.

Priority # 9 – Tuberculosis Screening

Priority Area: Tuberculosis Screening

Priority Type: Substance Use Treatment (SUT)

Population(s): Tuberculosis (TB)

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

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

Strategies to attain the objective:

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

Annual Performance Indicators to measure goal success
Indicator #: 1

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

Baseline Measurement: As of July 1, 2024, Tuberculosis screening and education is a continued required element in the BH-ASO contract for SUD treatment services.

First-year target/outcome measurement: For SFY 2026, ensure TB screening plans continue to be in contract with each of the ten BH-ASOs.

Second-year target/outcome measurement: For SFY 2027, review TB screening plans prior to the BH-ASO amendment and update as needed to ensure screenings and education services are being provided during SUD treatment services.

Data Source: Health Care Authority/BH-ASO Contracts

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

Data issues/caveats that affect outcome measures:

None

Priority # 10 – Opioid Use Disorder Treatment

Priority Area: Increase the number of adults receiving opioid use disorder treatment, support during recovery from OUD, and tools necessary to reduce deaths resulting from opioid overdose and poisoning.

Priority Type: Substance Use Treatment (SUT), Substance Use Recovery (SUR)

Population(s): Pregnant Women and Women with Dependent Children (PWWDC), Persons who Inject Drugs (PWID), Persons with or at risk of tuberculosis receiving SUD treatment services (TB), Persons in need of recovery support services from SUD (PRSUD)

Goal of the priority area: Increase accessibility of treatment for individuals experiencing opioid use disorder and support individuals in recovery from opioid use disorder.

Objective:

- Increase opportunities for incarcerated individuals to receive OUD assessment, OUD medication, sustained treatment throughout incarceration, and connection to continue treatment upon release or transfer
- OUD treatment penetration

Strategies to attain the objective:

- Partner with the University of Washington Addiction, Drug and Alcohol Institute (UW ADAI) to provide training and technical assistance to participating jails to increase the number of incarcerated individuals assessed for OUD, newly prescribed buprenorphine, methadone, or after shared decision making, naltrexone, or continuing treatment for individuals taking MOUD upon booking
- Contract with county, city and Tribal jails in Washington State to provide Medications for Opioid Use Disorder (MOUD) programs.
- Contracted jails will adhere to the MOUD standard of care, and this language is included in contracts, offering buprenorphine, methadone or naltrexone, and continuation of medications upon release.
- Treatment penetration rates

Annual Performance Indicators to Measure Goal Success

Indicator #: 1

Indicator: Increase the number of incarcerated people newly prescribed buprenorphine, methadone, or naltrexone.

Baseline Measurement: Baseline for SFY24: 4,294 incarcerated individuals newly prescribed buprenorphine or naltrexone.

First-year target/outcome measurement: Increase the number of incarcerated individuals newly prescribed buprenorphine, methadone, or naltrexone in SFY26 to 5,000.

Second-year target/outcome measurement: Increase the number of incarcerated individuals newly prescribed buprenorphine, methadone, or naltrexone in SFY27 to 6,000.

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

Description of Data: Baseline data collected includes the number of people incarcerated among the 19 programs who are inducted on buprenorphine, methadone or naltrexone for SFY25.

Data issues/caveats that affect outcome measures: SFY 25 targets could increase or decrease based on whether or not funding levels are changed in the Supplemental Budget.

Indicator #: 2
Indicator: Increase opioid use disorder treatment penetration rates.

Baseline Measurement: SFY24 54.8% penetration rate for Medicaid beneficiaries in need of opioid use disorder treatment.

First-year target/outcome measurement: Increase the percentage of Medicaid beneficiaries receiving needed treatment for OUD in SFY26 to 60%.
Second-year target/outcome measurement: Increase the percentage of Medicaid beneficiaries receiving needed treatment for OUD in SFY27 to 65%.

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

Description of Data: The population of focus was Medicaid beneficiaries (ages 13-64 years) with behavioral health diagnoses. Medicaid beneficiaries with non-Medicaid primary health care coverage (also referred to as third-party liability) and those who are dually enrolled in Medicaid and Medicare were excluded from the analyses, as complete health care utilization information may not be available for these individuals. Analyses were further restricted to individuals who met minimum Medicaid enrollment criteria (11 out of 12 months in the measurement year) to meet eligibility requirements for the treatment penetration rate metrics.

Medicaid beneficiaries with a SUD or OUD diagnosis are the primary focus of the Current State Assessment.

Data issues/caveats that affect outcome measures: Current data available only shows SFY17 through SFY19. 2019 is the last "non covid" year for which we have data. This analysis is currently being updated with data through SFY2022. This data could reveal unknown changes in treatment penetration that may be caused by the Covid 19 pandemic. This analysis will be available later this year. Once available, targets for this indicator may need to be revised

Environmental Factors and Plan

Access to Care, Integration, and Care Coordination

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

A venue for states to advance access to care is by ***ensuring that protections afforded by MHPAEA are being adhered to in private and public sector health plans, and that providers and people receiving services are aware of parity protections***. *SSAs and SMHAs can partner with their state departments of insurance and Medicaid agencies to support parity enforcement efforts and to boost awareness around parity protections within the behavioral health field. The following resources may be helpful:* ***The Essential Aspects of Parity: A Training Tool for Policymakers***; ***Approaches in Implementing the Mental Health Parity and Addiction Equity Act: Best Practices from the States***.

The integration of primary and behavioral health care remains a priority across the country to ensure that people receive care that addresses their mental health, substance use, and physical health problems. People with mental illness and/or substance use disorders are likely to die earlier than those who do not have these conditions.[1] *Ensuring access to physical and behavioral health care is important to address the physical health disparities they experience and to ensure that they receive needed behavioral health care.* ***States should support integrated care delivery in specialty behavioral health care settings as well as primary care settings***. *States have a number of options to finance the integration of primary and behavioral health care, including*

programs supported through Medicaid managed care, Medicaid health homes, specialized plans for individuals who are dually eligible for Medicaid and Medicare, and prioritized initiatives through the mental health and substance use block grants or general funds. States may also work to advance specific models shown to improve care in primary care settings, including Primary Care Medical Homes; the Coordinated Care Model; and Screening, Brief Intervention, and Referral to Treatment.

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

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

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

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

a) Adults with serious mental illness (SMI) / b) Adults with SMI and a co-occurring intellectual and developmental disabilities (I/DD)

Washington supports integrated services through integrated managed care, services are coordinated through a single health plan, including physical health, mental health, and substance use disorder (SUD) treatment.

HCA is currently planning for the launch of the Certified Community Behavioral Health Clinic (CCBHC) model in early 2027, which is an integrated behavioral health model with primary care screening. Under this model, all Washingtonians would be eligible to receive services, regardless of their insurance status. It would also offer a competitive rate structure to support sustainable, cost-based funding to behavioral health agencies, stabilizing their financial outlook and allowing them to focus on providing excellent care.

The request to fund the Washington Integrated Care Assessment (WA-ICA) through the Medicaid Transformation Waiver 2.0 was pended by Centers for Medicare and Medicaid Services (CMS). Thus, the funding source that the work group and HCA had anticipated for continued implementation is not available. HCA continues to prioritize clinical integration and will continue to look for ways to ensure future sustainability.

c) Pregnant women with substance use disorders

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

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

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

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

We are also providing services through most of our State Hub and Spoke Opioid Treatment networks and our Nurse Care Manager programs to provide Medications for Opioid Use Disorders to pregnant and parenting women.

d) Women with Substance Use Disorders who have Dependent Children

Washington is working to create options for Pregnant and Parenting Women through several pathways to build upon our existing PPW treatment network.

Work is underway with our SUD providers, our Medicaid office, Department of Health, and Department of Child Welfare to create a shared understanding of what 'Family Preservation' is and what it will take to support providers standing up a Substance Use Disorder Treatment Facility using a Family Preservation Model. Washington is also exploring and supporting what's known as a 'Rising Strong' model that will be modeled from a housing foundation and have services and supports of a residential model available to Pregnant and Parenting Women to support the ongoing safe and stable housing need. These models are both exploring the needs of families working toward and participation in dependency and/ or reunification.

We are also providing services through most of our State Hub and Spoke Opioid Treatment networks and our Nurse Care Manager programs to provide Medications for Opioid Use Disorders to pregnant and parenting women.

e) Persons who inject drugs

In 2019, Washington State Health Care Authority began a contract with University of Washington- Addictions, Drug & Alcohol Institute (ADAI) to support the community-based "Meds First" program then Nurse Care Manager Plus program, now called the Health Support Teams, to provide onsite, low-barrier access to buprenorphine. A key component of the service model was the addition of care navigation to support client engagement and retention in OUD treatment.

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

- Care team with a prescriber, nurse care manager, and at least one care navigator.
- Walk-in, same-day access to buprenorphine.

- Six months of follow-up care as a bridge to longer-term OUD treatment, onsite or in the community.
- Ongoing substance use seen as an opportunity for further engagement, not as treatment failure or reason for discharge.
- Shared decision making for medications for opioid use disorder.
- Counseling offered but not mandated.

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

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

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

Since 2020, the State Opioid Response Opioid Treatment Networks and Hub & Spokes provide HIV and viral Hepatitis screening, referrals and/or treatment to individuals with Opioid Use Disorder (OUD) or co-occurring OUD. Of the individuals provided medications for opioid use disorder since July 2021, 6,857 were provided testing and referrals for HIV treatment and 6,771 were provided testing and referrals for viral Hepatitis. These programs work within their organizations, subcontracted or community partners to provide these services. They are also encouraged to coordinate and collaborate with the Ryan White HIV/AIDS Program (RWHAP)

which provides a comprehensive system of care including medical care and support services for people living HIV who are uninsured or underinsured.

g) Persons with substance use disorders in the justice system

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

Since 2018, the participating State Opioid Response Opioid Treatment Network (OTN) jails have been responsible for inducting individuals with Opioid Use Disorder onto MOUD, screening and referring for re-entry services, eliminating barriers to recovery resources upon release, and providing overdose prevention education and naloxone kits. The OTN jails focus on establishing strong relationships with community and network partners to ensure individual recovery success. There are currently four (4) in Washington state located at the Benton County Jail, Franklin County Jail, Kitsap County Jail, and SCORE Jail.

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

- Opioid Use Disorder Screening, Clinical Opioid Withdrawal Scale (COWS)

- MOUD continuation or induction: offer all three FDA approved medications; buprenorphine, naltrexone and methadone when an OTP is available.

- Screen for and support acute withdrawal

- Reentry coordination/transition Services

- Naloxone and release kits

- Staffing: medical, case management, SUDP, peer specialists, and correctional officers

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

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

Initially HCA was instructed by the Washington State Legislature to use funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) Substance Use Prevention, Treatment and Recovery Services Block Grant (SUPTRS) to fund naloxone distribution across the state and was the inception of the Overdose Education and Naloxone Distribution (OEND) section at DOH. DOH provides overdose response training and distributing naloxone through local agencies, physical health settings, and emergency services. Activities engage professionals, first responders, local and regional stakeholders, and health care providers to reduce overdose risk and deaths among people who use heroin and prescription opioids. Per the Naloxone Distribution Plan, DOH has taken the lead on naloxone distribution and overdose response training. The objectives are:

1. Equip lay responders and professionals with overdose response training/naloxone through access at local agencies/ entities;

2. Educate health care providers, local agencies, and emergency services on opioid guidelines, patient overdose education, opioid use disorders, and naloxone distribution; and

3. Build and harmonize data infrastructures to inform resource allocation, maintain overdose surveillance, and measure outcomes;

4. Make sure there is not overlap of naloxone distribution between this program and the WA-PDO program; and

5. Work closely with HCA DBHR to develop a sustainability plan, to include funding, in preparation for the WA-PDO grant expiring in August 2026.

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

1. Develop overdose prevention strategic plans in five HNAs;

2. Equip law enforcement with overdose response training/naloxone;

3. Equip lay responders (LR) with overdose response training/naloxone;

4. Increase naloxone dispensed by pharmacists each year;

5. Educate health care providers on opioid guidelines, patient overdose education, and naloxone and opioid use disorders;

6. Develop new models of substance use treatment linkage and care coordination in five HNAs;

7. Facilitate coordination in five HNAs among local and regional stakeholders and with state agencies;

8. Build and harmonize data infrastructures to inform resource allocation, maintain overdose surveillance, and measure outcomes; and

9. Create knowledge translation infrastructure to disseminate emerging data, best practices, training, and technical assistance.

i) Other adults with substance use disorders

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

The continuum of care includes activities designed to engage and connect individuals to recovery services, such as outreach, screening in primary health care or other nonbehavioral health treatment settings, and case management services. Strategies and interventions will include Evidence Based/Evidence Informed Practices. Project goals are to increase the number of patients receiving medication for opioid use disorder by increasing capacity in a variety of settings and to enhance the integrated care that patients receive, improve retention rates for enrollees, decrease drug and alcohol use, decrease overdoses, and reduce adverse outcomes related to OUD.

The Contingency Management (CM) Waiver, approved under a Section 1115 Medicaid Demonstration, enables WA to implement evidence-based incentive-based interventions for Medicaid beneficiaries with stimulant use disorders. This approach, grounded in behavioral science, rewards individuals for meeting specific treatment by submitting drug-negative urine tests using voucher-based incentives. The waiver allows incentives up to the maximum annual cap of $599 per participant in accordance with federal guidance. The CM program is delivered through designated outpatient providers and community behavioral health centers and targets improved treatment retention, reduced stimulant use, and enhanced recovery outcomes.

j) Children and youth with serious emotional disturbances or substance use disorders/ k) Children and youth with SED and a co-occurring I/DD

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

participating in the learning collaboratives to support newer regions learning from regions that have stood up networks and multi-disciplinary teams.

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

Experience of Care and Health Outcomes (ECHO) has been used in physical medicine for a number of years as hub and spoke model to increase expertise of providers in remote areas. This model has more recently been used in the area of behavioral health and is now used to increase expertise of mental health providers to effectively treat mental health concerns of those with autism and intellectual and developmental delays (ASD/IDD). Lastly, Washington is deeply invested in expanding access to our Specialty care program for First Episode Psychosis - New Journeys through improving HIT resources to improve screening and access along with inclusion in our Medicaid rates toward the goals set by our legislature to have access across Washington based on prevalence and population.

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

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

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

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

generated by the HCA workgroup every three years. The most recent inquiries into the MCOs and workgroup report indicated that there were no current concerns with parity expectations. The legislature updated Washington's mental health parity requirements in 2025 and harmonized them with recently published final rules, requiring that medical necessity determinations be consistent with generally accepted standards of care and recommendations from nonprofit health care provider associations, requiring consistent rules for both mental health and substance use disorders, and eliminating harmful barriers to care.

3. Describe how the state supports the provision of integrated services and supports for individuals with co-occurring mental and substance use disorders, including screening and assessment for co-occurring disorders and integrated treatment that addresses substance use disorders as well as mental disorders.

Screening and assessment for COD is a cornerstone of Washington's integrated approach. The state mandates that behavioral health providers use comprehensive assessment tools such as ASAM criteria. Additionally, the Washington Integrated Care Assessment (WAICA) is used to evaluate a provider's readiness and effectiveness in delivering integrated care. Through statewide implementation of screening tools such as Screening, Brief Intervention, and Referral to Treatment (SBIRT), providers are able to identify both mental health and substance use conditions early and accurately. In addition to community providers, some schools and school districts utilize the SBIRT model to identify, prevent or reduce substance use, and support students' behavioral health and well-being. In treatment settings, Washington encourages integrated models where mental health and substance use services are delivered together, improving outcomes by treating the whole person. To further support co-occurring care, ASAM released the fourth edition of the ASAM criteria October 2023, along with the scheduled release of the adolescent and transition age youth (ATAY) volume in 2026. This edition will emphasize co-occurring, individual and family centered care in a more comprehensive, age-appropriate way for youth and young adults. The state plans to adopt both volumes January 2028. The State Opioid Response (SOR) grant plays a key role in these efforts by funding initiatives that expand access to integrated care, support workforce training, and promote evidence-based practices. SOR emphasizes the use of MOUD (Medications for Opioid Use Disorder) as a core component of treatment, combined with counseling and mental health support, ensuring that individuals receive comprehensive, coordinated care for both their substance use and mental health needs.

Integrated services also include Assertive Community Treatment (ACT), Program for Assertive Community Treatment (PACT), and contingency management—an approach that uses incentives to support treatment adherence, particularly for opioid, stimulant, and alcohol use disorders. These interventions are complemented by housing and peer support programs. For individuals requiring structured care beyond outpatient services, the state has developed

Intensive Behavioral Health Treatment Facilities, which provide small-scale residential treatment staffed by clinicians, psychiatric providers, and peer counselors.

To sustain these services, Washington invests heavily in workforce development. The HCA, in partnership with universities and provider networks, offers ongoing training in trauma-informed care, integrated treatment planning, and clinical best practices for COD.

Washington State's system reflects a strong commitment to evidence-based, integrated care for individuals with co-occurring disorders. Through Medicaid transformation, regulatory alignment, and investment in community-based resources, the state continues to enhance its system that promotes recovery, reduces fragmentation, and supports long-term well-being.

3(a). Please describe how this system differs for youth and adults.

Currently the MCOs are working on a collaborative Performance Improvement Project and have partnered with several primary care offices to reach out to children and youth who have been identified as needing follow up care to secure referrals for on-going behavioral health treatment services. This project includes providing care gap reports for identified children/youth, tracking phone call outreach, and referral processes. They are currently collecting data on these pilot projects and will incorporate the information and processes within their quality improvement work moving forward.

An additional youth SUD, co-occurring treatment facility plans to open in 2025. The Bridge Program and other state supported efforts work to provide SUD, co-occurring care to support young people transitioning out of public systems of care into safe and stable housing, reducing homelessness and improving health outcomes.

3(b). Does your state provide evidence based integrated treatment for co-occurring disorders (IT-COD), formerly known as IDDT? Please explain.

Washington State provides evidence-based integrated treatment for co-occurring mental health and substance use disorders through the Integrated Treatment for Co-Occurring Disorders (IT-COD) model. The state has incorporated IT-COD principles into its behavioral health system, offering coordinated, multidisciplinary care that addresses both mental health and substance use conditions simultaneously. This approach involves teams of specialists who deliver tailored, stage-wise treatment with assertive outreach, ensuring care is continuous and

responsive to the individual's readiness for change. Washington also prioritizes workforce development and provider training through conferences and professional development opportunities, such as the Washington State Co-Occurring Disorders and Treatment Conference, to promote the adoption of evidence-based practices. Additionally, initiatives funded by the State Opioid Response (SOR) grant support expanded access to integrated treatment and reinforce ongoing support for individuals with co-occurring disorders, ensuring comprehensive, coordinated care that enhances recovery outcomes across the state.

For Medicaid-funded services, co-occurring treatment is billed at the highest-level provider type the service is completed. The clinician would have to be dually licensed to complete both modalities, and the agency needs to be dually licensed also.

3(c) How many IT-COD teams do you have? Please explain.

As of now, Washington State does not monitor the exact number of Integrated Treatment for Co-Occurring Disorders (IT-COD) teams.

3(d) Do you monitor fidelity for IT-COD? Please explain.

Washington State does not systematically monitor fidelity to IT-COD.

3(e) Do you have a statewide COD coordinator?

No. We do not.

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

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

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

c) Efforts to integrate primary care into behavioral health settings

d) How the state provides integrated treatment for individuals with co-occurring disorders

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

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

- Multi-payer Primary Care Transformation Model – In collaboration with the state's purchasers, payers, and primary care provider community, HCA has been working to develop a new primary care transformation model (PCTM) for the state. This work strives to promote and incentivize integrated, whole-person, and team-based care. Develop high-functioning accountable care teams that address the goals and needs of the individual and family by efficiently organizing and coordinating care across the range of health system partners, inclusive of behavioral health. The Collaborative Care Model (CoCM) is a model of behavioral health integration that enhances "usual" primary care by adding two key services: care management support for clients receiving behavioral health treatment, and regular psychiatric or board-certified addiction medicine consultation with the primary care team, particularly regarding clients whose conditions are not improving. To support the CoCM model, HCA completed a state plan amendment to add this into the Medicaid benefit. Further guidance and support are provided through the physician related services billing guide, which supports primary care providers in implementation and understanding reimbursement for this team-based model and approach. Additionally, at the prompting of stakeholder engagement, HCA expanded reimbursement options by adding health and behavior codes to the billing guides. Washington has robust telehealth policies including payment parity and audio only services for established clients. These efforts, in concert with the Department of Commerce work to bolster access options for all of our physical health and behavioral health services across our state.

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

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

The data sharing efforts are also key work to ensure data sharing practices are a supporting bi-directional care.

Washington has also worked diligently to address state plan amendments to expand allowable providers including the addition of substance use disorder professionals, behavioral health support specialist, and licensed associates in an effort to expand access to behavioral health services in primary care settings.

(c) Efforts to integrate primary care into behavioral health settings:

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

Washington is also embracing the Certified Community Behavioral Health Clinic (CCBHC) model, which focuses on ensuring integrated outpatient services, as well as prevention and crisis stabilization. HCA is moving forward with an implementation plan with a goal that 90% of Washingtonians will be in a county or be within driving distance of a county with a CCBHC. Part of this work will involve working with stakeholders to determine the level of integration of primary care into these settings. Washington State was selected for a CCBHC planning grant that began January 1st, 2025, and runs through December 31st, 2025. Washington intends to apply for a demonstration period at the end of this grant.

d) How the state provides integrated treatment for individuals with co-occurring disorders

Washington State has established a comprehensive, integrated system to address the complex needs of individuals with co-occurring mental health, substance use disorders, and physical health needs. The foundation of this system lies in the full integration of behavioral and physical health care under Medicaid Managed Care Organizations (MCOs).

Clinical integration is being advanced in Washington to ensure that individuals and families receive the right care at the right time, regardless of where they are receiving care. Washington's approach aims to improve care coordination, health outcomes, and reduce costs. The state is focused on transforming primary care to be a more coordinated team-based approach and supporting community health worker programs. The state promotes the use of integrated clinical assessments to ensure that complex needs are addressed through integrated health services and/or care coordination. In treatment settings, Washington encourages integrated models where mental health and substance use services are delivered together with physical health, improving outcomes by treating the whole person.

Washington is working to enhance access to primary care services through Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) known as Community Health Centers (CHCs), in Washington. These non-profit, community-based centers focus on serving medically at-risk populations who are uninsured, underinsured, low-income, homeless, and beyond. CHCs provide a variety of services, including medical, mental health, dental, maternity support, pharmacy, and substance use disorder treatment.

Washington State is developing a Certified Community Behavioral Health Clinic (CCBHC) program with a planned launch of January 2027. CCBHC integrates Mental Health with Substance Use Disorder treatment as a core requirement of the program. Many of the behavioral health agencies in Washington State already have multidisciplinary teams and are well positioned to move into certification when it becomes available. CCBHC also integrates primary care screening into a behavioral health setting, as well as encouraging CCBHCs to develop Memorandums of Understanding (MOUs) with primary care providers in their local communities. These formalized relationships will allow for a streamlined referral process from behavioral health agency to primary care, and vice versa.

5. Describe how the state provides care coordination, including detail about how care coordination is funded and how care coordination models provided by the state vary based on the seriousness and complexity of individual behavioral health needs. Describe care coordination available to:

a) Adults with serious mental illness (SMI)

b) Adults with substance use disorders

c) Adults with SMI and I/DD

d) Children and youth with serious emotional disturbances (SED) or substance use disorders

e) Children and youth with SED and I/DD

Within Washington, care coordination is offered as a benefit for individuals receiving Medicaid through a managed care plan. We currently contract with five MCOs who all provide care coordination to children, youth and adults experiencing serious mental illness, serious emotional disturbances, I/DD and SUD. Each MCO has created levels of care coordination based on the needs of individuals and level of care coordination need. MCO care coordination funding is included within the per capita rates. Additionally, there are services, such as WISe (Wraparound with Intensive Services) and PACT (Program for Assertive Community Treatment) that contain care coordination as integral components.

MCOs are required to offer Wellness and Prevention services to all enrollees (including adults, children and youth with SMI, SED, substance use disorders, and/or I/DD), where individuals who are identified as needing care coordination services are referred to the appropriate service providers (including PCP, MH professionals, SUD professionals, DSHS) for follow up care and in a timely manner. MCO care coordinators work with enrollees to promote improved clinical outcomes, enrollee participation in care, continuity of care, increased self-management skills, improved adherence to prescribed treatment, and improved access to care and services.

MCOs provide care coordination to enrollees who are known as “high utilizers” who have behavioral health needs and current or prior criminal justice involvement. MCOs also provide care coordination for youth that utilize Private Duty Nursing (PDN).

For enrollees identified as needing Complex Case Management (CCM) or those with multiple chronic conditions, the MCO care coordinator will support the enrollee with a plan of care including addressing gaps in care, appropriate use of Evidence-based practices, promoting recovery using peer supports and community health workers, assisting with crisis/relapse prevention planning, coordination of assessments between providers, and supporting interoperable care plans.

MCOs must ensure care coordination for all enrollees under age 21 in accordance with EPSDT requirements. The MCO must follow up to ensure children receive the physical, mental, vision, hearing and dental services needed. MCOs also provide EPSDT coordination for any child serving agency and participate in a cross-system care plan. MCOs also must have a process for

facilitation of community reintegration from out of home placements (including state hospitals, state psychiatric facilities, children's long-term inpatient facilities, JR facilities, foster care, nursing and acute inpatient settings) for children, youth, and adults. MCOs also must be aligned with the Protocols for Coordination with Tribes and non-Tribal IHCPs.

MCOs have a designated staff as the Children's Long-Term Inpatient Program (CLIP) liaison, who coordinates with the regional CLIP committees and CLIP facilities and participates in regular treatment team meetings, referrals and applications, and collaboration with other child-serving systems involved in the youth's care. The youth involved include those with serious emotional disturbances, substance use disorders, and/or I/DD.

MCOs ensure that transitional services are provided to all enrollees who are transferring between settings and/or levels of care. This includes enrollees who participate in Health Home services, and those in community physical and behavioral health hospitals, residential treatment facilities, and long-term care facilities. MCOs must prioritize care coordination and discharge planning for enrollees who have been involuntarily detained and are likely to experience significant challenges for transfer or discharge.

MCOs also partner with HCA on the Reentry Medicaid Transformation Project (MTP) 2.0 Initiative to support the health and stabilization of incarcerated individuals.

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

Screening and assessment for COD is a cornerstone of Washington's integrated approach. The state mandates that behavioral health providers use validated screening tools such as ASAM criteria and the Integrated Dual Disorder Treatment (IDDT) assessment to identify mental health and substance use issues early in the treatment process. Additionally, the Washington Integrated Care Assessment (WAICA) is used to evaluate a provider's readiness and effectiveness in delivering integrated care. Through statewide implementation of screening tools such as Screening, Brief Intervention, and Referral to Treatment (SBIRT), providers are able to identify both mental health and substance use conditions early and accurately. In addition to community providers, some schools and school districts utilize the SBIRT model to identify, prevent or reduce substance use, and support students' behavioral health and well-being. In treatment settings, Washington encourages integrated models where mental health

and substance use services are delivered together, improving outcomes by treating the whole person.

Integrated services also include Assertive Community Treatment (ACT), Program for Assertive Community Treatment (PACT), and contingency management—an approach that uses incentives to support treatment adherence, particularly for opioid, stimulant, and alcohol use disorders. These interventions are complemented by housing and peer support programs. For individuals requiring structured care beyond outpatient services, the state has developed Intensive Behavioral Health Treatment Facilities, which provide small-scale residential treatment staffed by clinicians, psychiatric providers, and peer counselors.

To sustain these services, Washington invests heavily in workforce development. The HCA, in partnership with universities and provider networks, offers ongoing training in trauma-informed care, integrated treatment planning, and clinical best practices for COD.

Washington State's system reflects a strong commitment to evidence-based, integrated care for individuals with co-occurring disorders. Through Medicaid transformation, regulatory alignment, and investment in community-based resources, the state continues to enhance its system that promotes recovery, reduces fragmentation, and supports long-term well-being.

Currently the MCOs are working on a collaborative Performance Improvement Project and have partnered with several primary care offices to reach out to children and youth who have been identified as needing follow up care to secure referrals for on-going behavioral health treatment services. This project includes providing care gap reports for identified children/youth, tracking phone call outreach, and referral processes. They are currently collecting data on these pilot projects and will incorporate the information and processes within their quality improvement work moving forward.

An additional youth SUD, co-occurring treatment facility plans to open in 2025. The Bridge Program and other state supported efforts work to provide SUD, co-occurring care to support young people transitioning out of public systems of care into safe and stable housing, reducing homelessness and improving health outcomes.

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

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

Washington has also engaged in efforts to improve access to care for young children and their families, through specific work around developmentally appropriate mental health assessment and diagnosis, including:

- Revised reimbursement policies to adequately fund assessments best practices, including assessments that take multiple sessions and/or take place in home and community settings (i.e., natural environments). An evaluation of the impact of these reimbursement changes on service delivery is being conducted, beginning in SFY24 and continuing through this current SFY25.

- Free training in the DC:0-5, the developmentally appropriate diagnostic manual for young children's mental health, which is recommended by both CMS and SAMHSA. Training will continue through SFY24-25.

- Additional tools and resources to support the use of the DC:0-5, including a community-informed DC:0-5 crosswalk, and updated administrative code to allow the use of the DC:0-5 in individual service records. Additional tools and resources will be developed through SFY24-25.

7. ***Describe how the state supports the provision of integrated services and supports for individuals with co-occurring mental and intellectual/developmental disorders (I/DD), including screening and assessment for co-occurring disorders and integrated treatment that addresses I/DD as well as mental disorders. Please describe how this system differs for youth and adults.***

Intensive Residential Treatment (IRT) services are designed to work with adult individuals being discharged or diverted from a long-term civil commitment or state hospital who have struggled to remain in their community settings. Behavioral health services are provided by a multi-disciplinary team where the services are recovery-focused and promote stability, safety, and community integration. Individuals receiving IRT services are residing in Department of Social and Health Services (DSHS)/ Aging and Long-Term Support Administration (ALTSA) housing settings. IRT services are modeled after Assertive Community Treatment (ACT) principles and, as such, are offered through a multidisciplinary team. In an effort to better serve individuals with co-occurring intellectual/developmental disorder (I/DD), a specialized IRT team was developed and currently serves individuals in King, Pierce, and South Snohomish Counties. This team has the capacity to serve up to 50 individuals. In addition to the utilization of ACT principles, this specialized IRT team receives training that supports their work with individuals with I/DD to ensure that treatment is integrated and supportive.

Wraparound with Intensive Services (WISe) is an outpatient service delivery model that uses wraparound principles to provide intensive state plan services to Medicaid recipients through age 20 that need this level of service. In addition to providing therapy and peer services, WISe provides care coordination. This can allow for integration of Applied Behavioral Analysis (ABA) with mental health services for participants needing both interventions. WISe providers are also invited to staff clinical challenges at regular ECHO sessions. ECHO is described above in question J. ABA is covered by Medicaid for both adults and children in Washington State.

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

None at this time.

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

Much of the mental health treatment and recovery service efforts are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among individuals 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 as soon as possible following initial symptoms and reducing possible lifelong negative impacts such as loss of family and social supports, unemployment, incarceration, and increased hospitalizations [Note: 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 SMI or SED]. The duration of untreated mental illness, defined as the time interval between the onset of symptoms and when an individual gets into appropriate treatment, has been a predictor of outcomes across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be a negative prognostic factor. However, earlier treatment and interventions not only reduce acute symptoms but may also improve long-term outcomes.

The 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-5TR (APA, 2022). 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 the 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 experiencing first episode of psychosis (FEP). RAISE was a set of federal government- sponsored studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP. The 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.*

States 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 experiencing 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.

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

Model(s)/EBP(s) for ESMI/FEP	Number of programs
New Journeys - coordinated specialty care model based on Navigate (EBP).	19

2. ***Please provide the total budget/planned expenditure for ESMI/FEP for FY 26 and FY 27 (only include MHBG funds).***

FY2026	FY2027
$3,571,220	$3,571,220

3. ***Please describe the status of billing Medicaid or other insurances for ESMI services. How are components of the model currently being billed? Please explain.***

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

In July 2022, Washington implemented a team-based rate for Medicaid. Billing through the Medicaid team-based rate is projected to result in reimbursements of $415,584 per team annually, covering an estimated 76% of New Journeys team costs. Washington's implementation of a Medicaid team-based rate expands the funding available to the New Journeys network. Since launching the team-based rate, New Journeys transitioned 10 teams from federal block grant funds.

In July of 2025, together with Mercer actuarial group, Washington implemented an additional service-based enhancement called the New Journeys encounter rate and implemented the new CMS code H2041. The addition of the third service-based enhancement allows for choice between two separate reimbursement structures based upon threshold of intensity and 24 months of intervention. The updated financing will help expand Medicaid funding, covering team costs more fully, providing more options and flexibility in billing to support rural CSC adaptations.

Additional funds to account for non-Medicaid activities are paid for with State funds through Managed Care Organizations (MCO) Integrated Managed Care (IMC) & Integrated Foster Care (IFC) wraparound contracts. The non-Medicaid components of the model are funded, over and above, the team-based rate to pay for 36% of the team's time to provide non-Medicaid activities required for fidelity. Two slots per team for underinsured participants are funded through regional Behavioral Health Administrative Organizations (BH-ASO) contracts. Training, quality improvement and fidelity activities, as well as start-up and case building of new teams are supported through federal block grant funds.

4. Please provide a description of the programs that the state funds to implement evidence-based practices for those with ESMI/FEP.

New Journeys is a coordinated specialty care model based on NAVIGATE, curated to meet the needs of those in Washington experiencing first episode psychosis. The multidisciplinary team offers a coordinated and specialized approach that targets an individual's unique needs and provides more intensive recovery support compared to regular outpatient treatment. Each New Journeys team is structured using 4.25 Full Time Equivalents (FTEs). Each team serves no more than 30 individuals at a given time.

The New Journeys team members include:

- Program Director/Family Education Provider (1.0 FTE)
- Psychiatric Care Provider (0.25 FET)
- Individual Resiliency Training (IRT) Clinician (1.0 FTE)
- Supported Employment and Education (SEE) Specialist (1.0 FTE)
- Peer Support Specialist (0.5 FTE)
- Case Manager and/or Registered Nurse Care Manager (0.5 FTE)

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

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

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

The University of Washington (UW) Implementation Team leads the fidelity review process utilizing the NAV-Fs Fidelity scale (Meyer-Kalos et al., 2025), adapted for the NAVIGATE model from the First Episode Psychosis Services Fidelity Scale (FEPS-FS). Secondary co-reviewers are recruited from the New Journeys teams, aiming for at least one trained co-reviewer per New Journeys team. Fidelity reviews consist of a two-day site visit conducted by two fidelity reviewers (one from UW and one from a New Journeys team) annually.

Before the review, reviewers work collaboratively with the team and the Measurement Delivery and Evaluation Team at Washington State University (WSU) to develop the two-day site visit agenda. Fidelity review data sources include:

- Pre-fidelity review survey completed by New Journeys team members and the Measurement Delivery and Evaluation Team at Washington State University who will use information from the data platform.
- Observation of the weekly team meeting
- Interviews with New Journeys team members
- Interviews with New Journeys participants
- New Journeys program documents (e.g., community education materials, admission criteria, screening tools), and
- Participant health records (e.g., assessments, treatment plans, progress notes)
- After the review, fidelity reviewers independently rate all items on the NAVIGATE Fidelity Scale, then develop consensus ratings for each item, which culminate in a final average score between 1 (low fidelity) and 5 (high fidelity).

The WSU Evaluation and Technical Assistance team for the New Journeys aligns national standards of coordinated specialty care, regular administration of measures to assess treatment

progress and outcomes are a core component of the New Journeys model. To ensure that partnering agencies are able to fulfill this component, the Evaluation and Technical Assistance team provides the following services: 1) access to the data platform for measurement delivery; 2) annual and ad hoc technical assistance training via Zoom scheduled at site's convenience; 3) monthly meetings and reports with team members (typically Program Directors) where measurement completion rates and measurement quality are discussed. Teams must meet a 70% minimum measurement completion rate per month.

Measurement-based care (MBC) decision making is considered an evidence-based practice that typically involves the use of standardized measures to guide treatment practice or treatment planning (Lewis et al., 2018). Studies on measurement-based care suggest that when it is used in outpatient behavioral health settings, it improves participant outcomes (Lambert, 2002; 2003). New Journeys team members are required to collect and complete measures as part of the evaluation, but it also serves to assist teams in decision making and treatment planning. The New Journeys measurement battery and data platform provides the tools (i.e., built-in measures, automatic scoring, graphical feedback) for this purpose.

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

- Improvement to individual clinical outcomes
- The ability to observe changes over time that can be used by teams in weekly and treatment planning meetings
- Enhancement of clinician judgements with the use of objective assessments
- The ability for participants to receive feedback about their treatment progress in real time

Using the data completed by clients and providers pertaining to engagement and retention of youth and families with New Journeys, clinical outcomes of participants, and experiences from individuals and their supports, the WSU Measurement Delivery and Evaluation Team are able to evaluate the New Journeys Network. The WSU Measurement Delivery and Evaluation Team generates quarterly and yearly reports which provide both qualitative and quantitative data analysis to inform network-wide program development and implementation and contributes to the sustainability of funding.

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

Yes.

7. Explain how programs increase access to essential services and improve client outcomes for those with an ESMI/FEP?

Those experiencing ESMI/FEP often present special issues related to engagement. The use of outpatient mental health services is the lowest in young adulthood. Data suggests that 46% of those who met criteria for SMI do not receive treatment (IOM, 2015, CMHS, 2011; National

Survey of Drug Use and Health, 2018). Research indicates youth and young adults benefit from support to navigate transitions from hospitals, jails, crisis situations and independent living. New Journeys often provide these supports during a vital time in someone's life.

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

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

8. Please describe the planned activities for FY 206 and FY 2027 for your state's ESMI/FEP programs.

- Continued expansion of New Journeys teams based on incidence and population needs.
- Continued development of adaptations to address the needs of those at risk of being underserved.
- CSC model development focused on shared decision making and peer and family support.
- Training and support for the ESMI/FEP behavioral health workforce
- Implement expanded diagnostic criteria and updated fidelity tool to include affective psychosis in 2025.

9. Please list the diagnostic categories identified for your state's ESMI/FEP programs.

Eligibility Criteria	**The psychosis is NOT known to be *caused* by:**
1. Ages 15-40 2. Psychotic symptoms have been present between 1 week and 2 years 3. Primary diagnosis of one of the following: a. Schizophrenia b. Schizoaffective disorder c. Schizophreniform disorder d. Brief psychotic disorder e. Delusional disorder f. Other specified psychotic disorder g. Bipolar disorder with psychotic features	1. Pervasive developmental disorder and/or autism spectrum disorder 2. Psychotic disorder due to another medical condition including medication induced psychotic disorder 3. The temporary effects of substance use or withdraw

h. Major depression with psychotic features 4. IQ over 70	

The NAVIGATE model is not evidence-based to provide treatment to those experiencing co-morbid intellectual disability with an IQ below 70. This is due to the likely need for ongoing, intensive supports that are above and beyond what NAVIGATE/New Journeys is able to provide but can be provided within the Developmental Disabilities system. Program Directors are not responsible for assessing an individual's IQ but should be aware of this eligibility criterion when gathering collateral information and records during the screening process.

During differential diagnosis, a Program Director should differentiate between psychotic-like symptoms that are sometimes seen in autism spectrum disorder and new and emerging symptoms of psychosis indicative of a psychotic disorder. NAVIGATE/New Journeys does not include any training or specific interventions focused on managing the symptoms, behaviors, and cognitive impairments associated with autism. New Journeys providers can work to determine the severity of the symptoms associated with autism and whether or not psychosis is the primary presenting problem. The UW Implementation Team provides consultation related to Differential Diagnosis to help assist Program Directors in these situations.

10.What is the estimated incidence of individuals with a first episode psychosis in the state?

Incidence rates of psychosis in Washington State match those across the U.S. and worldwide. In SFY 2023, Washington State Department of Social and Health Services' Research and Data Analysis (RDA) Division identified 4,106 Medicaid enrollees under the age of 65 in Washington who received their first episode of a psychosis diagnosis. Among them, 2,541 individuals from the ages 15 to 40 received New Journeys-qualifying diagnoses and potentially met New Journeys admissions criteria (Figure 5). The estimated annual incidence rate of FEP was 248 per 100,000 Apple Health (Medicaid) enrollees. The annual incidence rate for individuals potentially needing New Journeys admissions criteria was 347 per 100,000. Dually enrolled individuals, those with intellectual disabilities and autism spectrum disorders, and those with a history of out-of-home placement have higher incidence rates than the general Medicaid population. Additionally, 2,871 individuals received the first diagnosis of affective psychosis. The incidence rate was 173 per 100,000 and 80 per 100,000 for non-affective psychosis and affective psychosis, respectively.

Please note that these are likely conservative estimates of the incidence of FEP, because they do not include individuals who were experiencing symptoms but did not encounter a Medicaid provider. This estimate only accounted for individuals enrolled in Medicaid or dually enrolled in Medicare during two of the last three years. Individuals newly enrolled in Medicaid or those with commercial insurance or uninsured were not accounted for.

11. What is the state's plan to outreach and engage those with a first episode psychosis who need support from the public mental health system?

The onset of psychosis marks a pivotal window for intervention—neurological changes and functional decline occur rapidly in the first year, making early, accurate identification essential. Yet, distinguishing early psychosis from normative experiences or non-psychotic disorders is complex, especially given varied clinical presentations and inconsistent access to specialized care across the state. To mitigate these challenges, the Washington State Health Care Authority used FY24 and FY25 Federal Community Mental Health Block Grant funds to partner with the University of Washington to co-develop a Statewide professional public health campaign to raise awareness of early psychosis. New Journeys teams engage in local public education and outreach efforts in order to hasten the identification and rapid referral of youth and young adults experiencing symptoms.

As part of the efforts to increase awareness through public education, the New Journeys network has worked together to update the New Journeys website for improved user experience and to enhance the low-barrier referral process for services in communities across Washington. Similarly, the public education includes an informational website as well as a self-screener that can provide recommendations to reach out for a New Journeys referral if indicated.

The Psychosis CARE conference is a two-day virtual event focused on Early Identification and Treatment of First Episode Psychosis and marketed across networks throughout Washington State. The event is organized in collaboration with the Health Care Authority and representatives of the New Journeys network of clinicians and trainers from all over the state. The event aimed to provide attendees with education, resources, best practices, and hopeful outlooks for supporting and identifying individuals experiencing first episode psychosis. In 2024 over 1,300 individuals from Washington and across the nation registered for this event, and 764 individuals attended the live event.

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

- Public education about the benefit of CSC and why it is better than regular outpatient services as well as strategies for public education addressing stigma for psychosis.
- Autism and FEP
- Cannabis use and psychosis and co-occurring substance use disorders
- Intersection of financing with CSC and CCBHCs
- Financing Strategies and Parity for CSC

Person Centered Planning (PCP)

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

In addition to adopting PCP at the service level, for PCP to be fully implemented it is important for states to develop systems which incorporate the concepts throughout all levels of the mental health network. PCP resources may be accessed from ***https://acl.gov/news-and-events/announcements/person-centered-practices-resources***

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

Yes

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

N/A

3. Describe how the state engages people with SMI and their caregivers in making health care decisions and enhance communication.

The Program of Assertive Community Treatment (PACT), the First Episode Psychosis New Journeys program, and the Wraparound with Intensive Services (WISe) models define a specific process for treatment planning that are very inclusive of the individuals and their family or others identified by the individual as part of their treatment team. For WISe, there is an individualized cross system care plan (CSCP) that ensures that the mental health treatment plan

is supportive of other system requirements and plans including those from child welfare, juvenile justice, education (IEP or 504 plan), and medical treatments. These are person-centered explorations of strengths and challenges across multiple life domains. Fidelity monitoring specifically looks for inclusion of natural supports and PACT fidelity monitoring ensures that all members of PACT teams receive person centered planning training.

In addition to those individuals receiving PACT, New Journeys, and WISe services, all individuals receiving outpatient mental health services are engaged in the development of an individualized service plan. Washington State promotes the use of Mental Health Advance Directives, a legal written method by which an individual can communicate their decisions about mental health treatment as well as who is authorized to make decision on their behalf in advance of times when they are incapacitated.

Another program that can assist young people who are exiting behavioral health systems and do not have safe or stable housing identified is the Youth & Young Adult Housing Response Team (YYAHRT), led by the Department of Children, Youth & Families, that youth shall be discharged into safe and stable housing. YYAHRT brings all pertinent stakeholders and community members to team meetings centered around youth voice and choice. This gives families and young people an opportunity to not only discuss potential housing options but to speak directly with their managed care organization and community providers to gain support connecting to behavioral health services, such as making appointments, or to coordinate services within the community. YYAHRT also holds weekly lunch conferences where a community member, family/caregiver, or agency can receive direct technical assistance.

The Bridge Coalition created by NorthStar Advocates is another space where managed care organizations, community members, youth & young adults with lived experience can share current behavioral health experiences and trends and learn about new community agencies and programs that can support young people going through recovery services.

The Center of Parent Excellence (COPE) project (hosted by A Common Voice, the longest standing Family-run Organization) was developed as a support to enhance our System of Care framework. The project is intended to provide a pathway for Washington State parents who are accessing and navigating the children's behavioral health system to have peer support to ease their journey, whenever possible. This peer support allows parent/caregivers to have mentoring and coaching, by a parent with lived experience, to ensure that the needs of the family are captured in all treatment and planning processes for their families, as it is important that when families ask for help, they feel as though they received the help they asked for.

Additional Services offered are one on one support for parents/caregivers accessing and navigating behavioral health services on behalf of their child. Support can be accessed by a phone call or email to the lead parent support specialist for their county. Support groups are provided twice a month for parents that are set up by region. Assistance to WISe Child and Family Teams (CFTs) is available upon request to address their concerns and barriers. The COPE

project also tracks recurring system gaps and barriers and advances them to the local and/or regional FYSPRT.

The WA State Children's Behavioral Health Statewide Family Network was developed to ensure a dedicated space for parents to share their lived experience with the behavioral health system, identify themes and work to bring their voices of lived experience to the system that serves them. They host an annual Parent Training Weekend; this is a dedicated space for parents/caregivers and is free to all parents/and caregivers. They also host an annual Behavioral Health Summit which is open to parents/caregivers, youth and system partners. They have workgroups and subcommittees to make recommendations to the system based on their lived experience. They are embarking on providing training to parents/caregivers on legislative advocacy, that includes specific rules about not spending state and federal dollars to lobby.

They also collaborate with community members who identify as having lived/living experiences in behavioral health including family and care givers to build strong relational partnerships to gain valuable insight into what works and what does not in a real-world setting, leading to more effective behavioral health interventions and services that are more closely aligned with individual and community needs and preferences.

4. Describe the person-centered planning process in your state.

Individuals receiving their mental health treatment under the authorization of the managed care benefit 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 on client needs and preferences. Programs such as WISe, New Journeys, Kids Mental Health Washington (KMHWA), Mobile Response and Stabilization Services (MRSS), Cener of Parent Excellence, and PACT stress an even greater emphasis on person centered planning, as described above.

5. What methods does the SMHA use to encourage people who use the public mental health system to develop Psychiatric Advance Directives?

Washington state code requires behavioral health providers to ensure anyone accessing care and/or their caretakers be informed of advanced directives and supported in completing them

if requested. HCA provides policy education and support to behavioral health providers toward this goal.

Program Integrity

There is a strong emphasis on ensuring that Block Grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that the federal government and the states have a strong approach to assuring program integrity. Currently, the primary goals of the federal government's program integrity efforts are to promote the proper expenditure of Block Grant funds, improve Block Grant program compliance nationally, and demonstrate the effective use of Block Grant funds

*While some states have indicated an interest in using Block Grant funds for individual co-pays deductibles and other types of co-insurance for behavioral health services, states are reminded of restrictions on the use of Block Grant funds outlined in **42 U.S.C. § 300x–5** and **42 U.S.C § 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)**, there are periodic site visits to MHBG and SUPTRS BG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SUPTRS BG funds can only be used for individuals with or at risk for SUD. The 20% minimum primary prevention set-aside of SUPTRS BG funds should be used for universal, selective, and indicated substance use prevention. 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 SUPTRS BG resources are to be used to support, not supplant, services that will be covered through private and public insurance. In addition, the federal government and states need to work together to identify strategies for sharing data, protocols, and information to assist Block Grant program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SUPTRS BG funds are allocated to support evidence-based substance use primary prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the MHBG and SUPTRS BG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2)

ensuring that individuals are aware of the covered mental health and SUD benefits; (3) ensuring that consumers of mental health and SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of mental health and 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.

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

Yes

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

Yes

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

DBHR program managers work with their contractors to review claims, identify overpayments, and educate providers and others on block grant program integrity issues.

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

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

On a monthly basis:

- Budget and Finance Division in conjunction with DBHR leadership conducts monthly reviews of the block grant budgets.

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

Primary Prevention

SUPTRS BG statute requires states to spend a minimum of 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment which programs (A) educate and counsel the individuals on substance use and substance use disorders; and (B) provide for activities to reduce the risk of substance use and substance use disorders by the individual. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must serve both the general population and sub-groups that are at high risk for substance use. 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, misuse and substance use disorders 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 priority populations in activities that exclude alcohol, tobacco, and other drug use.*
4. ***Problem identification and Referral*** *that aims at identification of those who have engaged in illegal/age-inappropriate use of tobacco or alcohol, and those individuals who have engaged in initial use of illicit drugs, in order to assess if the behavior can be addressed by education or other interventions to prevent further use.*
5. ***Community-based processes*** *that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and*

6. ***Environmental strategies*** *that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the use 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 serve populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Please respond to the following questions:

Assessment

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

2. ***Does your state collect the following types of data as part of its primary prevention assessment process?***
   Yes. This assessment includes data on:
   a. Consequences of substance-using behaviors.
   b. Substance-using behaviors such as any underage alcohol use, binge drinking, opioid use, cannabis use, vapor/e-cigarette use, and commercial tobacco use.
   c. Intervening variables including risk and protective factors; and
   d. Other: Local contributing factors.

3. ***Does your state collect needs assessment data that include analysis of primary prevention needs for the following population groups?***
   Washington collects needs assessment data on the following population groups:
   - Children (under age 12);
   - Youth (ages 12-17);
   - Young adults/college age (age 18-26);
   - Adults (ages 27-54);
   - Rural communities; and
   - Other: Disability status of youth, Housing insecurity status of youth

4. ***Does your state use data from the following sources in its primary prevention needs assessment?***
   For its primary prevention needs assessment, Washington uses two state-developed survey instruments: the Healthy Youth Survey and the Young Adult Health Survey. Additionally, Washington uses the following national sources:
   - The National Survey on Drug Use and Health,

- Behavioral Risk Factor Surveillance System,
- Youth Risk Behavior Surveillance System,
- Pregnancy Risk Assessment Monitoring System, and
- Monitoring the Future.

The following indicators are used:

a. WA Department of Health, Center for Health Statistics, Death Certificate Data:
i. Alcohol related deaths;
ii. Other drug related deaths;
iii. Opioid overdose deaths
iv. Suicide Death Rates
b. Uniform Crime Reporting:
i. Alcohol related arrests
ii. Drug related arrests
c. Office of Superintendent of Public Instruction:
i. High School On-Time / Extended Graduation Rates
d. Comprehensive Hospital Abstract Reporting System (CHARS):
i. Alcohol-Injury Related Hospitalizations
ii. Any Non-Fatal Drug Overdose Hospitalizations
iii. Any Non-Fatal Opioid Overdose Hospitalizations
iv. Intentional Self-Harm Hospitalizations
e. WA Department of Transportation and WA State Highway Safety Commission
i. Fatalities and Serious Injury from Crashes: Alcohol-Related Traffic Injuries and Alcohol-Related Traffic Fatalities.
ii. Young Drivers in Fatal Crashes Positive for Delta-9 THC
f. Washington Healthy Youth Survey:
i. Underage Drinking (10th Grade);
ii. Marijuana Misuse/Abuse (10th Grade);
iii. Prescription Misuse/Abuse (10th Grade);
iv. Pain Killer User (10th Grade)
v. Tobacco Misuse/Abuse (10th Grade);
vi. E-Cigarette/Vapor Products Misuse/Abuse (10th Grade);
vii. Polysubstance Misuse/Abuse (10th Grade);
viii. Sad/Hopeless in Past 12 Months (10th Grade);
ix. Suicide Ideation (10th Grade);
x. Suicide Plan (10th Grade);
xi. Suicide Attempt (10th Grade);
xii. Bullied/Harassed/Intimidated (10th Grade);
xiii. Source of Alcohol, Pain Killers Used to Get High; Marijuana; Vapor Products (10th Grade);
xiv. Perception of Availability of Alcohol, Marijuana, Cigarettes; Opioids (10th Grade);

xv. **Risk Perception of Alcohol, Marijuana (10th Grade); and**
xvi. **Knowledge of Laws, Perception of Enforcement – Alcohol, Marijuana (10th Grade),**

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

h. **Pregnancy Risk Assessment Monitoring System (PRAMS):**
   i. **Pregnant Women Report Alcohol Use Any Time During Pregnancy**

i. **Washington State Liquor and Cannabis Control Board:**
   i. **Count of State Liquor Licenses;**
   ii. **Count of State Marijuana Store Licenses and Processor Licenses**

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

Yes

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

Washington State's Evidence-Based Program Workgroup (EBP Workgroup) is involved in developing and maintaining a list of evidence-based programs and strategies that our sub-recipients for primary prevention services are permitted to select from. The EBP Workgroup is comprised of researchers and experts within and outside of Washington state. Membership has included representatives from University of Washington's Social Development Research Group (UW SDRG), Washington State University's Improving Prevention through Action Research Lab (WSU IMPACT lab), the Washington State Institute for Public Policy, the Prevention Research Collaborative (formerly the Prevention Research Sub-Committee), and Pacific Institute for Research and Evaluation.

Criteria for Programs, policies, and practices that are determined to be evidence-based center on the availability of high-quality research evidence showing consistently positive and no harmful impacts for a given program or strategy. To receive a designation of evidence-based (EBP), the program or strategy must also have specific descriptions of its components and be 'dissemination ready', meaning training and technical assistance materials are actively maintained.

Prevention section staff and the EBP Workgroup rely on several evidence-based registries for prevention programs to aid these decisions, including the Blueprints for Healthy Youth Development registry, the California Evidence Based Clearinghouse, CrimeSolutions, and the Washington State Institute for Public Policy's inventories of EBP, RBP and Promising practices for children's services. When a program/strategy is not captured on any of these registries, tools have been developed with our university partners to be used by the EBPW to analyze the quality of the available research studies' methodology, outcomes, intervention specificity, and dissemination readiness. This now includes a practice-based evidence checklist which describes prevention programs' theory of change, evidence of participant engagement, and evidence of impact (including qualitative and participatory evidence).

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

Capacity Building

1. ***Does your state have a statewide licensing or certification program for the substance use primary prevention workforce?***
   Yes. In Washington the IC&RC certification the Certified Prevention Professional (CPP) credential is available through the Prevention Specialist Certification Board of Washington (PSCBW). DBHR requires state staff and prevention providers with CPWI grants to obtain a CPP. DBHR supports individuals pursuing this credential by offering training opportunities that count toward both the initial application and renewal of the CPP. These trainings include continuing education credits (CEHs) in required content areas. DBHR also hosts multiple conferences throughout the year, allowing participants to select sessions that align with the CEH categories required for certification. Additionally, DBHR offers the Washington Substance Abuse Prevention Skills Training (SAPST) to meet foundational training requirements. Since 2015, DBHR has required community coalition coordinators to be credentialed.

2. ***Does your state have a formal mechanism to provide training and technical assistance to the substance use primary prevention workforce?***
   Yes. DBHR provides training and technical assistance for communities and prevention providers as they implement prevention services. The training plan covers the entire calendar year and includes the following components which provide a number of recurring workforce and capacity development opportunities in a variety of formats:
   - Coordinator trainings to increase prevention providers' capacity to implement the Washington Strategic Prevention Framework (SPF) model. These trainings include:
     - New Coordinator Basic Training – overview of Community Prevention and Wellness Initiative and SPF Models.

    - Community Data Book Training – how to use data to conduct a community needs assessment.
    - Goals, Objectives, Strategy Selection Training – how to prioritize local conditions and intervening variables to select program objectives and outcomes.
    - Evaluation Training – how to conduct an evaluation of programs and use results
    - CADCA Boot Camp – a four-day, interactive training to increase providers' capacity for coalition development.
- Substance Abuse Prevention Skills Training (SAPST) - a multi-day training grounded in SAMHSA's Strategic Prevention Framework offered to practitioners to provide a comprehensive introduction to the substance abuse prevention field, and foster the knowledge and skills needed to implement effective, data-driven prevention.
- Annual Training: DBHR hosts multiple annual trainings including two state-wide conferences for prevention professional and community partner capacity building and youth prevention team capacity building.
- These conferences provide educational 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.
- DBHR also hosts an annual Coalition Leadership Institute (CLI) each summer. This multi-day event shares important updates and practical system knowledge for CPWI coalition coordinators
- Monthly Training: DBHR hosts on-going, optional monthly training sessions during the 3rd hour of the on-line monthly CPWI Learning Community Meetings attended by sub-recipients.
- Webinar training topics *include emerging research and data as well as information on evidence-based practices and strategies to support program implementation.*
- DBHR Technical Assistance Training and On-going Support:
- DBHR provides regular and timely Technical Assistance to CPWI communities covering:
- Budgeting;
- Strategic plan development;
- Action plan updates;
- SPF implementation;
- Contract compliance; and
- The Substance User Disorder Prevention and Mental Health Promotion Online Management Information System (MIS);

- SDRG Intensive Technical Assistance and Training and On-going Support:

- DBHR contracts with University of Washington's Social Development Research Group (SDRG) to deliver coordinated training opportunities. Training topics are determined by DBHR in an ongoing and responsive manner adapting to the needs of Washington's prevention workforce, including but not limited to:
    - Core prevention science knowledge;
    - Strategic plan development;
    - Evidence-based program selection;
    - Evidence-based program fidelity and adaptation;
    - Effective program implementation;
    - Evaluating implementation outcomes (i.e., process and outcome measurement);
- SDRG also provides Intensive Technical Assistance to high need CPWI communities covering topics including coalition strategic planning, capacity building, community planning, and more.

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

Planning

1. ***Does your state have a strategic plan that addresses substance use primary prevention that was developed within the last five years?***
   Yes. The first State of Washington Substance Abuse and Mental Health Promotion Five-Year Strategic Plan was developed in 2012. It was updated in 2015, 2017, 2019 and the

2023-2027 Strategic Plan was released in July 2023. This strategic plan guides and coordinates the substance use disorder prevention and mental health promotion efforts across WA state agencies.

2. ***Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SUPTRS BG?***
   Yes.

3. ***Does your state's prevention strategic plan include the following components?***
   The state's prevention strategic plan includes the following components:
   - Based on needs assessment datasets the priorities that guide the allocation of SUPTRS BG primary prevention funds;
   - Timelines;
   - Roles and responsibilities;
   - Process indicators;
   - Outcome indicators;

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

   a) **Does the composition of the council represent the demographics of the state?**
      Yes

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

   If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based?
   The EBP Workgroup is comprised of researchers and experts within and outside of Washington state, from University of Washington's Social Development Research Group and Washington State University's Improving Prevention through Action Research Lab, with input from the Washington State Institute for Public Policy, the prevention research sub-committee, and Pacific Institute for Research and Evaluation. Washington State's Evidence-Based Program Workgroup (EBP Workgroup) is involved in developing and maintaining a list of evidence-based programs and strategies that our sub-recipients for primary prevention services are permitted to select from.

Programs, policies, and practices are determined to be evidence-based by DBHR staff and the EBP Workgroup according to criteria that center on the availability of high-quality research evidence showing consistently positive and no harmful impacts for a given program or strategy. As of 2024-2025, this also includes a pilot process to review evidence with a more holistic lens that includes theories of change, indications of participant engagement, and qualitative and participatory methods. To receive a designation of evidence-based (EBP), the program or strategy must also have specific descriptions of its components and be 'dissemination ready', meaning training and technical assistance materials are actively maintained.

Prevention section staff and the EBP Workgroup rely on several evidence-based registries for prevention programs to aid these decisions, including the Blueprints for Healthy Youth Development registry, the California Evidence Based Clearinghouse, CrimeSolutions, and the Washington State Institute for Public Policy's inventories of EBP, RBP and Promising practices for children's services. When a program/strategy is not captured on any of these registries, tools have been developed with our university partners to be used by the EBPW to analyze the quality of the available research studies' methodology, outcomes, intervention specificity, and dissemination readiness. This now includes a practice-based evidence checklist which describes prevention programs' theory of change, evidence of participant engagement, and evidence of impact (including qualitative and participatory evidence).

Implementation

1. ***States distribute SUPTRS BG primary prevention funds in a variety of different ways. The following apply in WA:***
    - SSA staff directly implements primary prevention programs and strategies;
    - The SSA has statewide contracts;
    - The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts;
    - The SSA funds county, city, or tribal government to provide prevention services;
    - The SSA funds community coalitions to provide prevention services.
    - The SSA funds individual programs that are not part of a larger community effort.
    - The SSA directly funds other state agency prevention programs.
    - The SSA funds the universities for program services and for research, evaluation, training, and staff support.
    - The SSA funds vendors to coordinate prevention trainings and conferences.

2. ***Please list the specific primary prevention programs, practices, and strategies that are funded with SUPTRS BG primary prevention dollars in at least one of the six prevention strategies.***

Community-Based Processes – SUPTRS supports the Community Coalition Coordinator's ongoing role as staff and supports the local (required) community coalition in operating, community mobilizing, and building capacity for substance use prevention service delivery through the Community Prevention and Wellness Initiative (CPWI). Funding for this category also supports tribal staff to implement prevention programs via Sovereign Nation Agreements.

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

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

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

Education – SUPTRS funding will continue to support prevention services that provide education from trained educators/facilitators to program participants according to communities' strategic plans. Education is delivered through evidence-based recurring or single-session workshops, direct service programs and educational seminars. Alternatives – SUPTRS funding will continue to support youth focused substance-free activities and mentoring. Substance-free activities provide safe, adult-monitored environments for youth and teens, critical in communities where youth opportunities are limited. Mentoring activities provide consistent and supportive relationships, connecting youth with other adults in the community. Alternative activities are implemented in conjunction with educational programs and strategies.

Environmental – SUPTRS 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 SUPTRS BG dollars are used only to fund primary prevention services not funded through other means?***
   Yes. In addition to SUPTRS, the State of Washington provides 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 SUPTRS dollars are used as required by the grant. DBHR's contracts specify approved uses of these funds and PSMs engage in routine monitoring activities to ensure alignment with these requirements.

Evaluation

1. ***Does your state have an evaluation plan for substance use primary prevention that was developed within the last five years?***
   Yes. DBHR contracts with Washington State University to evaluate the effectiveness of the Community Prevention and Wellness Initiative (CPWI). CPWI is a strategic, data-informed, prevention service delivery model aimed at preventing youth alcohol, tobacco, marijuana, opioid, and other drug use by targeting school-based and community-based prevention efforts in communities throughout the state (there are currently 96 CPWI communities).
   This evaluation approach addresses two specific questions:
   1) How do 10th Grade substance use and related risk/protective factors in CPWI communities change over time?
   and
   2) Are the changes/trends over time different for CPWI communities compared to similar non-CPWI communities in Washington State? The evaluation draws from the state Healthy Youth Survey as well as community-level program and evaluation data. In addition, this effort evaluates community readiness (to implement CPWI) and characteristics of successful coalitions. Results of these evaluations are disseminated to CPWI communities and other stakeholders through reports, community presentations, and consultations. The evaluation products include the following:

   - Developmental Trend Analysis Report (State Level)
   - Impact Over Time Outcome Report (State Level)
   - RE-AIM Report (State Level)

- Coalition Progress Questionnaire Standardization (State and Community Level)
- Program-level outcomes for CPWIs Report (State Level)
- Additional reporting through regional and national conferences and publications

2. ***Does your state's prevention evaluation plan include the following components?***
   Washington's plan includes the following components:
   a. Establishes methods for monitoring progress toward outcomes, such as prioritized benchmarks – via the state Substance Use Prevention and Mental Health Promotion Online Management Information System (SUD Prevention and MH Promotion MIS);
      - Includes evaluation information from sub-recipients – via the SUD Prevention and MH Promotion MIS;
   b. Includes SAMHSA National Outcome Measurement (NOMs) Requirements;
   c. Establishes a process for providing timely evaluation information to stakeholders;
   d. Formalizes a process for incorporating evaluation findings into resource allocation and decision-making.
   e. Other:
      - Reports to sub-recipients
      - Evaluation of trainings offered by DBHR.

3. ***Please check those process measures listed below that your state collects on its SUPTRS BG funded prevention services:***
   Washington collects the following measures:
   a. Numbers served (for individual participants, aggregate counts, and population reach);
   b. Implementation fidelity;
   c. Participant satisfaction
   d. Number of evidence-based programs/practices/policies implemented;
   e. Attendance;
   f. Demographic information
   g. Other:
      - Service hours.
      - Number of Visitors to Table/Booth or Event.
      - Number of Pick Ups/Destruction Trips.
      - Number of Reverse Distributor Mailers Distributed.
      - Number of Lock Boxes Distributed.
      - Number of Pounds Collected.
      - Number of materials distributed.
      - Number of People Reached by Radio Media Disseminated
      - Number of People Reached by TV

- Number of People Reach By Newspaper/Press Release/Magazine Disseminated
- Number of People Reach By Poster/Stickers Disseminated
- Number of People Reach By Billboard Disseminated
- Number of People Reached By Events
- Number of Events
- Number Users of Webpage
- Number Unique Page Views of Webpage
- Number Followers on Social Media
- Number of Social Media Posts (FB, Twitter, Etc) on Social Media
- Number Clicked Post/Tweet (From All Posts/Tweets That Month) on Social Media
- Number Who Reacted To Post To All Posts/Tweets (Liked/Shared/Commented) on Social Media
- Social Media Display Ads
- Number of Website Clicks on Social Media Display Ads

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

WA Department of Health:

- Alcohol related injury/accident (hospitalization);
- Other drugs related injury/accident (hospitalization);
- Tobacco related deaths;
- Alcohol related deaths;
- Other drug deaths – Drug related deaths; and
- Opioid related deaths – All Opioids; Prescription; Heroin.

a. Uniform Crime Reporting:
   - Arrests – Alcohol Violation;
   - Arrests – Alcohol Related;
   - Arrests – Drug Violation; and
   - Arrests – Drug Related.

b. Office of Superintendent of Public Instruction:
   - High School Extended Graduation Rate (includes on-time graduation).
   - Comprehensive Hospital Abstract Reporting System (CHARS):
   - Suicide and attempts.

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

d. Washington Healthy Youth Survey:
   - Underage Drinking (10th Grade);

- Marijuana Use (10th Grade);
- Use of Prescription Drugs Not Prescribed (10th Grade);
- Pain Killer Use to get High (10th Grade)
- Tobacco Use (10th Grade);
- E-Cigarette/Vapor Products Use (10th Grade);
- Polysubstance Use (10th Grade);
- Sad/Hopeless in Past 12 Months (10th Grade);
- Suicide Ideation (10th Grade);
- Suicide Plan (10th Grade);
- Suicide Attempt (10th Grade);
- Bullied/Harassed/Intimidated (10th Grade);
- Source of Alcohol, Pain Killers Used to Get High; Marijuana; Vapor Products (10th Grade);
- Perception of Availability of Alcohol, Marijuana, Cigarettes; Opioids (10th Grade);
- Risk Perception of Alcohol, Marijuana (10th Grade); and
- Knowledge of Laws, Perception of Enforcement – Alcohol, Marijuana (10th Grade)

e. Washington Young Adult Health Survey:
   - Young Adult (18-25) Marijuana Use;
   - Alcohol Use; and
   - Source of Marijuana
   - Pregnancy Risk Assessment Monitoring System (PRAMS):
   - Pregnant Women Report Alcohol Use Any Time During Pregnancy. Washington State Liquor and Cannabis Control Board:
   - Count of State Liquor Licenses;
   - Count of State Marijuana Store Licenses and Processor Licenses; and
   - Monthly revenue/sales of products.

Statutory Criterion for MHBG

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

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

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

Contracts with Behavioral Health Administrative Service Organizations and Managed Care Organizations cover a wide variety of services in support of the individuals to live in their communities. Some examples of the services provided on a community level include crisis services, outpatient mental health counseling, group and family treatment, medication management, and medication monitoring. There is also higher level of outpatient resources such as intensive services for youth and families, respite services, the program of assertive community treatment (PACT), and high intensity services. Additionally, there are recovery support services made available for individuals in the community that include care coordination, engagement and outreach, peer support, supportive housing, supported employment, clubhouses, and housing subsidies and supports through Housing and Recovery through Peer Services (HARPS).

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

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

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

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

4. ***Describe 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 BH ASO 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 BH ASO utilizes hospital liaisons within their region to assist with the discharge planning at the state hospitals, as well as the evaluation and treatment facilities. Washington State recently provided additional funding to the BH ASOs to further support dedicated discharge planners at the evaluation and treatment centers. Additionally, the state launched a Peer Bridger Pilot program that integrates peer counselors into each BH ASO hospital liaison team to facilitate discharge planning and to support successful transition and continuity of care as individuals return to their communities.

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

Criterion 2 – Response to how the state calculates prevalence and incidence rates:

In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus.

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

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

Data Source: BHDS, P1 claims assumed to reflect MH services in the FIMC regions using an HCA approved algorithm with known limitations.

Washington State does not have a methodology or data to estimate incidence rates.

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

Data Source: BHDS, P1 claims assumed to reflect MH services in the FIMC regions using an HCA approved algorithm with known limitations.

Washington State does not have a methodology or data to estimate incidence rates.

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

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

Criterion 4 – Response to question:

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

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

b. Describe your state's targeted services to the homeless population

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

c. Describe your state's targeted services to the older population.

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

Criterion 5 – Describe your state's management systems.

DBHR uses MHBG funds to purchase and provide training to community mental health providers across the state. Examples of training include training in PACT fidelity and technical assistance and those EBPs included in the PACT model (CBT, Supported Employment, and Supportive Housing), Supportive Housing, Supported Employment, and Cognitive Behavioral Therapy for Psychosis. DBHR also purchases training for increasing the workforce of Certified Peer Counselors and provides training for Designated Mental Health Professionals who are responsible for providing on-site emergency evaluations of individuals who may need voluntary or involuntary treatment. Since April 1, 2018, these individuals have also been responsible for responding to emergencies with either mental health issues or issues revolving around substance use disorders. We trained the entire statewide work force in conducting SUD evaluations and co-occurring evaluations for voluntary and involuntary treatment.

Describe your states current telehealth capabilities, how your state uses telehealth modalities to treat individuals with SMI/SED, and any plans/initiatives to expand its use:

Washington State allows telehealth to be used for any behavioral health encounter if it is HIPAA compliant and only if it's "safely and effectively delivered", to be used for all encounters except residential, intake assessment, and group treatment.

In recent years, telehealth has evolved within Washington, including rapid policy change to support the continuation of care direct support of telemedicine for providers and patients, as well as collaboration with partners in telehealth.

Our current policies fully support the delivery of services via telehealth, audio visual or audio only, and we require these services to be paid at parity with in-person services.

Washington has leaned into the benefits and ability to reach more people with telehealth technology and will be thoughtful on continuing to focus on the growth and expansion of telehealth as safety and efficacy are clarified. Washingtons need currently is on education and training for providers to meet the needs of individuals seeking behavioral health services that have access and transportation challenges.

Footnotes (For criterion 5):

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

Substance Use Disorder Treatment

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

Improving access to treatment services

1. Does your state provide:

a) A full continuum of services:

i) Screening

Yes

ii) Education

Yes

iii) Brief intervention

Yes

iv) Assessment

Yes

v) Withdrawal Management (inpatient/residential)

Yes

vi) Outpatient

Yes

vii) Intensive outpatient

Yes

viii) Inpatient/residential

Yes

ix) Aftercare

Yes

X) recovery support

Yes

b) Services for special populations:

Targeted services for veterans?

No

Adolescents?

Yes

Older adults?

No

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

1. Does your state meet the performance requirement to establish and or maintain new programs or expand programs to ensure treatment availability?

a) Yes

2. Does your state make prenatal care available to PWWDC receiving services, either directly or through an arrangement with public or private nonprofit entities?

a) Yes

3. Have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care?

a) Yes

4. Does your state have an arrangement for ensuring the provision of required supportive services?

a) Yes

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

a) Open assessment and intake scheduling?

Yes

b) Establishment of an electronic system to identify available treatment slots?

Yes

c) Expanded community network for supportive services and healthcare?

Yes

d) Inclusion of recovery support services?

Yes

e) Health navigators to assist clients with community linkages?

Yes

f) Expanded capability for family services, relationship restoration, and custody issues?

Yes

g) Providing employment assistance?

Yes

h) Providing transportation to and from services?

Yes

i) Educational assistance?

No

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

Strategies for prioritizing pregnant women are contained within the contract language between the state of Washington and the Managed Care Organizations (MCOs). The MCOs must publicize the availability of treatment services to PPW clients at the facilities, as well as the fact that PPW clients receive priority admission.

The MCOs work with agencies to get pregnant individuals into services within 24 hours, and if a residential placement is not available interim services are provided. If residential treatment is not needed, the individual is enrolled in outpatient treatment. When services are not available, the provider is required to ensure the following:

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

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

- Primary medical care for women, including referral for prenatal care and childcare while the women are receiving such services.
- Primary pediatric care including immunization for their children.
- SUD treatment and other therapeutic interventions for women which may address issues of relationships, sexual and physical abuse, and parenting are provided.
- Provide, directly or through arrangements with other public or nonprofit private entities, childcare to individuals participating in assessment and treatment activities,

and supportive activities such as support groups, parenting education, and other supportive activities when those activities are recommended as part of the recovery process noted in the individual's treatment plan.

• Substance Used Disorder Assessment Services specific to PPW.

• Services specific to Post-Partum Women.

• Services may continue to be provided for up to one year postpartum.

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

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

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

Persons Who Inject Drugs (PWID)

1. Does your state fulfill the:

a) 90 percent capacity reporting requirement?

Yes

b) 14–120-day performance requirement with provision of interim services?

Yes

c) Outreach activities?

Yes

d) Monitoring requirements as outlined in the authorizing statute and implementing regulation?

Yes

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

a) Electronic system with alert when 90 percent capacity is reached?

No

b) Automatic reminder system associated with 14–120-day performance requirement?

No

c) Use of peer recovery supports to maintain contact and support?

Yes

d) Service expansion to specific populations (e.g., military families, veterans, adolescents, older adults)?

No

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

Strategies for prioritizing persons who inject drugs (PWID) is contained within the contract language between the state of Washington and the MCOs. The MCOs must publicize the availability of treatment services to PWID at the facilities, as well as the fact that PWID receive priority admission. In addition, the MCOs must ensure that outreach is provided to priority populations. The outreach activities must be specifically designed to reduce transmission of HIV and encourage PWID to undergo treatment.

If treatment services are not immediately available, then interim services are made available until an individual is admitted to a substance abuse treatment program. The purpose of the service is to reduce the adverse health effects of such abuse, promote the health of the individual, and reduce the risk of transmission of the disease.

The MCOs are required to submit a yearly project plan on how the services and the requirements in the contract will be adhered to. The project plans are reviewed and approved by DHBR. The MCOs are required to submit annual progress reports that include what outreach models were used to PWID to enter treatment.

Tuberculosis (TB)

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

a) Yes

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

a) Business agreement/MOU with primary healthcare providers?

Yes

b) Cooperative agreement/MOU with public health entity for testing and treatment?

Yes

c) Established co-located SUD professionals within FQHCs?

No

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

The MCOs must directly or through arrangement with other public entities, make tuberculosis services available to individuals receiving SUD treatment. The services must include tuberculosis counseling, testing, and provide for or referring individuals infected with tuberculosis for appropriate medical evaluation and treatment.

In the case an individual in need of treatment services is denied admission to the tuberculosis program based on the lack of capacity the MCO will refer the individual to another provider of tuberculosis services. The MCOs must conduct case management activities to ensure the individual receives tuberculosis services.

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

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

No

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

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

No

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

Yes

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

No

Syringe Service Programs

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

Yes

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

Service System Needs

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

Yes

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

a) Workforce development efforts to expand service access?

Yes

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

Yes

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

Yes

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

No

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

No

Service Coordination

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

Yes

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

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

Yes

b) Establish a program to provide trauma-informed care

Yes

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

Yes

Charitable Choice

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

Yes

2. Does your state provide any of the following:

a) Notice to Program Beneficiaries?

No

b) An organized referral system to identify alternative providers?

Yes

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

No

Referrals

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

Yes

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

a) Review and update of screening and assessment instruments?

Yes

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

Yes

c) Identify workforce needs to expand service capabilities?

Yes

Patient Records

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

a) Yes

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

a) Training staff and community partners on confidentiality requirements?

Yes

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

Yes

c) Updating written procedures which regulate and control access to records?

Yes

d) Review and update of the procedure by which clients are notified of the confidentiality of their records include the exceptions for disclosure?

Yes

Independent Peer Review

1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers?

a) Yes

2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C.§ 300x-52(a)) and 45 § CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program involved.

a) Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved

The state completes an annual independent peer review of its providers. The BH-ASO regions are required to submit the names of providers who will be reviewed as well as independent peer reviewers from each of the regions in the state. The state has an administrative policy in place that defines the purpose and scope of the reviews. The plan for the FFY25 review will have four substance use treatment providers (6.3%) to be reviewed and three mental health providers (7.3%) to be reviewed. Reviews are happening during August and September 2025.

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

a) Development of a quality improvement plan?

Yes

b) Establishment of policies and procedures related to independent peer review?

Yes

c) Development of long-term planning for service revision and expansion to meet the needs of specific populations

Yes

4. Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, such as the Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds?

a) No

b) If Yes, please identify the accreditation organization(s)

i) Commission on the Accreditation of Rehabilitation Facilities

ii) The Joint Commission

iii) Other (please specify)

Criterion 7 and 11: Group Homes for Persons in Recovery and Professional Development

Group Homes

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program?

Yes

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

a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service?

Yes

b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing?

Yes

Professional Development

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opportunity to receive training on an ongoing basis, concerning:

a) Recent trends in substance use disorders in the state?

Yes

b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services?

Yes

c) Performance-based accountability?

Yes

d) Data collection and reporting requirements?

Yes

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

a) A comprehensive review of the current training schedule and identification of additional training needs?

Yes

b) Addition of training sessions designed to increase employee understanding of recovery support services?

Yes

c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services?

Yes

d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort?

Yes

3. Has your state utilized the Regional Prevention, Treatment and/or Mental Health Training and Technical Assistance Centers (TTCs)?

a) Prevention TTC?

Yes

b) SMI Adviser?

No

c) Addiction TTC?

Yes

d) State Opioid Response Network?

No

e) Strategic Prevention Technical Assistance Center (SPTAC)?

Yes

Waivers

Upon the request of a state, the Secretary may waive the requirements of all or part of the sections 1922(c), 1923, 1924 and 1928 (42 U.S.C. § 300x-32(f)).

1. Is your state considering requesting a waiver of any requirements related to:

a) Allocations Regarding Women

No

2. Is your state considering requesting a waiver of any requirements related to intravenous substance use (300x-23)?

No

3. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus

a) Tuberculosis

No

b) Early Intervention Services Regarding HIV

No

4. Additional Agreements

a) Improvement of Process for Appropriate Referrals for Treatment

No

b) Professional Development

No

c) Coordination of Various Activities and Services

No

Please provide a link to the state administrative regulations that govern the Mental Health and Substance Use Disorder Programs.

https://apps.leg.wa.gov/wac/default.aspx?cite=182

Uniform Reporting System and Mental Health Client-Level Data (MH-CLD)/Mental Health Treatment Episode Data Set (MH-TEDS)

Health surveillance is critical to the federal government's ability to develop new models of care to address substance use and mental illness. Health surveillance data provides decision makers, researchers, and the public with enhanced information about the extent of substance use and mental illness, how systems of care are organized and financed, when and how to seek help, and effective models of care, including the outcomes of treatment engagement and recovery. Title XIX, Part B, Subpart III of the Public Health Services Act (42 U.S.C. §300x-52(a)), mandates the Secretary of the Department of Health and Human Services to assess the extent to which states and jurisdictions have implemented the state plan for the preceding fiscal year. The annual report aims to provide information aiding the Secretary in this determination.

42 U.S.C. §300x-53(a) requires states and jurisdictions to provide any data required by the Secretary and cooperate with the Secretary in the development of uniform criteria for data collection. Data collected annually from the 59 MHBG grantees is done through the Uniform Reporting System (URS), Mental Health Client-Level Data (MH-CLD), and Mental Health Treatment Episode Data Set (MH-TEDS) as part of the MHBG Implementation Report. The URS is an initiative to utilize data in decision support and planning in public mental health systems, fostering program accountability. It encompasses 23 data tables collected from states and territories, comprising sociodemographic client characteristics, outcomes of care, utilization of evidence-based practices, client assessment of care, Medicaid funding status, living situation, employment status, crisis response services, readmission to psychiatric hospitals, as well as expenditures data. Currently, data are collected through a standardized Excel data reporting template. The MHBG program uses the URS, which includes the National Outcome Measures (NOMS), offering data on service utilization and outcomes. These data are aggregated by individual states and jurisdictions.

In addition to the aggregate URS data, Mental Health Client-Level Data (MH-CLD) are currently collected. SMHAs are state entities with the primary responsibility for reporting data in accordance with the reporting terms and conditions of the Behavioral Health Services Information System (BHSIS) Agreements funded by the federal government. The BHSIS Agreement stipulates that SMHAs submit data in compliance with the Community Mental Health Services Block Grant (MHBG) reporting requirements. The MH-CLD is a compilation of demographic, clinical attributes, and outcomes that are routinely collected by the SMHAs in monitoring individuals receiving mental health services at the client-level from programs funded or provided by the SMHA.

MH-TEDS is focused on treatment events, such as admissions and discharges from service centers. Admission and discharge records can be linked to track treatment episodes and the treatment services received by individuals. Thus, with MH-TEDS, both the individual client and the treatment episode can serve as a unit of analysis. In contrast, with MH-CLD, the client is the sole unit of analysis. The same set of mental health disorders for National Outcome Measures (NOMs) enumerated under MH-CLD is also supported by MH-TEDS. Thus, while both MH-TEDS and MH-CLD collect similar client-level data, the collection method differs.

Please note: Efforts are underway to standardize the client level data collection by requiring states to submit client-level data through the MH-CLD system. Currently, over three-quarters of states participate in MH-CLD reporting. Starting in Fiscal Year 2028, MH-CLD reporting will be mandatory for all states. States that currently submit data through MH-TEDS are encouraged to begin transitioning their systems now and may request technical assistance to support this transition process

This effort reflects the federal commitment to improving data quality and accessibility within the mental health field, facilitating more comprehensive and accurate analyses of mental health service provision, outcomes, and trends. This unified reporting system would promote efficiency

in data collection and reporting, enhancing the reliability and usefulness of mental health data for policymakers, researchers, and service providers.

Please Respond to the following items:

1. ***Briefly describe the SMHA 's data collection and reporting system and what level of data is reported currently (e.g., at the client, program, provider, and/or other levels).***

The Washington State Health Care Authority (HCA) collects behavioral health data required for block grant reporting using the Behavioral Health Data System (BHDS). BHDS is a database designed to collect client information for individuals receiving treatment and services for mental health (MH) and substance use disorders (SUD). The following entities are required to submit supplemental data: Behavioral Health Agencies (BHAs) contracted with Managed Care Organizations (MCOs) and Behavioral Health Administrative Service Organizations (BH-ASOs) to provide behavioral health treatment services, freestanding Evaluation and Treatment Facilities (E&Ts), non-hospital Secure Withdrawal Management facilities, and Stabilization facilities. These entities must be licensed by the Department of Health as to be eligible to receive public funds from Medicaid, state/local funding sources, or federal block grants.

BHDS collects the data elements required by the Combined Substance Use and Mental Health TEDS State Instruction Manual. In addition, providers are required to submit updated information about clients who have received continued care at intervals specified by state regulations or federal reporting requirements. In addition to client-level data, BHDS also collects data elements that reflect provider-, payer-, and program-specific information. These data are submitted by HCA's contracted MCOs and BH-ASOs.

2. ***Is the SMHA 's current data collection and reporting system specific to mental health services or it is part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).***

The BHDS is part of a larger ecosystem of data managed by HCA. This ecosystem includes ProviderOne (P1). ProviderOne is the data platform to which all Medicaid providers submit claims for processing payment for services, and encounter forms tied so specific services rendered under contractual arrangements that do not pay fee-for-service (and which are not tied to payment).

The BHDS does not collect behavioral health data from entities not required to report data to the BHDS, which includes state hospitals and providers that do not receive public funds. State hospital data are collected and maintained by the Department of Social and Health Services (DSHS). BHDS collects no data on services for physical health conditions, medications distributed by pharmacies, durable medical equipment (DME), or long-term services and supports (LTSS).

Clients in the BHDS can be linked at the individual level to data in ProviderOne for clients in the BHDS with an assigned ProviderOne ID. Additional information about MH and SUD diagnoses, treatment and recovery services are available from Medicaid claims processed in ProviderOne. Together, these data can create a fuller picture of services a client receives across publicly funded programs. However, this linkage is only available for individuals enrolled in Medicaid and only for services submitted to ProviderOne. Neither the BHDS nor ProviderOne collect data on Medicare services.

HCA has not developed the capacity to link individuals in the BHDS or Provider One with data in other health care data systems managed by HCA, such as the All-Payer Claims Database (APCD) and systems supporting the Public Employees Benefits and State Employees Benefits systems.

3. ***What is the current capacity of the SMHA in linking data with other state agencies/entities (e.g., Medicaid, criminal/juvenile justice, public health, hospitals, employment, school boards, education, etc.)?***

As noted above, HCA has internal capacity to link supplemental data collected in BHDS with service encounter data collected in ProviderOne. Our partner agency, Department of Social and Health Services (DSHS) maintains an integrated client data base which contains information from a wide range of social services (Child welfare, economic support services, criminal justice) that is matched with service encounter data from ProviderOne. DSHS also collects data from state hospitals.

HCA draws information about providers licensed as behavioral health agencies (BHAs) from the Department of Health (DOH) to support federal reporting requirements. Beginning in 2018, DOH has served as the state licensing authority for health care providers in Washington State. Through interagency agreement for data-sharing, HCA has received a daily or weekly feed from DOH containing information about every BHA service location, including the owner's name and contact information, mailing address, primary staff contacts at the service location, license

status, and services authorized for delivery at each location under the license. DOH assigns a unique BHA credential number (BHA Credential ID) to each BHA service location associated with an owner. DOH does not have statutory authority to collect billing NPIs from licensed entities. In order to link location-specific information about providers with client-level data, HCA curates a crosswalk between BHA Credential ID and billing NPI. Providers in operation prior to 2018 also have a unique identifier assigned from a legacy system formerly managed by DSHS. Historical claims contain this Legacy ID. Thus, for federal reporting to the Treatment Episodes Data Set (TEDS), HCA maintains a crosswalk between Legacy ID, BHA Credential ID, and billing NPI.

4. Briefly describe the SMHA 's ability to report evidence-based practices (EBPs) including Early Serious Mental Illness (ESMI and Behavioral Health Crisis Services (BHCS) outcome data at the client-level.

There are two ways we have capacity to report on this. For the pediatric population, HCA has developed a reporting process that is integrated with our encounter data system (P1). Currently this captures a subset of EBPs used in mental health treatment services provided to the birth to age 18 Medicaid population, primarily EBP use in individual treatment sessions.

For the adult population, selected EBPs, including delivery of BH crisis services, are reported using a combination of encounter and supplemental data. Our capacity to report primarily includes delivery of services and characteristics of services provided but does not include clinical effectiveness measures.

5. Briefly describe the limitations of the SMHA 's existing data system.

Data completeness is a challenge in Washington State because of complex and fragmented data reporting systems and our limited ability to connect and compare our systems for a complete story. Washington faced significant reporting challenges from 2016 to 2023 as the state integrated physical, behavioral health services and reporting systems. HCA has made continuous improvements to address these challenges. Data in Washington State is collected by multiple systems increasing the complexity of data matching, management and analysis activities.

For example, State Hospitals (SH) are not included as a domain within HCA. Instead, SH data is maintained by DSHS, as is Single Bed Certification (SBC) data. This includes any budget and

expenditure figures. Additionally, the Washington Department of Health (DOH) is that licenses and certifies BHAs. Because the DOH and HCA data systems are not integrated, HCA must use a backend process to link licensing and certification information from DOH with HCA systems at the provider level. The success of this linking process requires providers to submit accurate and updated licensure information to P1, but because HCA and DOH systems are not integrated, HCA cannot independently validate this information.

6. What strategies are being employed by the SMHA to enhance data quality?

As part of Washington's efforts to continue to improve our behavioral health data infrastructure, we applied for and received enhanced Federal Financial Participation (FFP) through the CMS Advance Planning Document (APD) for System Development process. Our state legislature has also prioritized and provided enhanced funding for the past two legislative sessions in support of these efforts.

In the past year, with changes in division, agency, and state administration, HCA has initiated large-scale BH data quality improvement projects. As part of this work, HCA enlisted the assistance of our federal partners to provide technical assistance and insight into how systems work together (TEDS and I-TF). Additionally, HCA continues to work closely with our contractors to provide technical assistance on reporting activities and ensure data completeness. HCA has implemented a data quality and completeness process for BH services, which allows HCA to identify any missing or incomplete data that would be included in TEDS. HCA also implemented contract language to help enforce compliance.

Effective March 1, 2025, HCA initiated the requirement that all BHAs report their BHA licensing number on all claims. Unfortunately, at this time not all BH providers have the IT infrastructure to successfully implement this change. While BH-ASOs are doing technical assistance to providers to help make the change, at this point not all P1 claims have a BHA certification number. As noted above, HCA is not able to independently validate the certification information submitted by BHAs due to system limitations.

WA DOH, as the BHA licensing authority, does not collect billing NPIs associated with the license because statutory language does not give them authority to collect billing NPIs. Billing NPI is the only provider identifier in ProviderOne that links encounter data with the provider service location. HCA has put significant staff effort into curating crosswalks between billing NPIs and licensing numbers that identify service locations.

Currently, BHDS is not integrated with HCA's financial data system. While financial data is tracked across payers, providers, and programs, HCA has limited ability to link this data with service episode characteristics at the individual client level (BHDS data). HCA is exploring options for enhancing this capacity.

7. Please describe any barriers (staffing, IT infrastructure, legislative, or regulatory policies, funding, etc.) that would limit your state from collecting and reporting data to the federal government.

Some of the barriers that are limiting Washingtons ability to report data include: staff turnover coinciding with a state hiring freeze due to a budget deficit; higher staff workloads and longer transition times due to staffing limitations; and reduced access to state resources to support this work. In addition, rapidly changing data requirements and inconsistency in data definitions, as well as changes to processes and procedures to submit to federal systems, can further exacerbate these barriers.

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

Washington is connected to many technical assistance resources for behavioral health data reporting and has no additional technical assistance needs at this time. We will stay in close communication with our project officers as we continue to work on improving our data completeness and infrastructure.

We continue to appreciate the support offered by our federal partners to expand our understanding of the relationships across all federal data reporting platforms (I-TF, TEDs, WebBGAS reporting tables, etc.). We are continuing to seek alignment of data elements in our various systems with the federal data systems to enhance our reporting capacity and consistently meet all federal requirements.

Crisis Services

There is a mandatory 5 percent set-aside within MHBG allocation for each state to support evidence-based crisis systems. The statutory language outlines the following for the 5 percent set-aside:

…….to support evidence-based programs that address the crisis care needs of individuals with serious mental illnesses and children with serious emotional disturbances, which may include individuals (including children and adolescents) experiencing mental health crises demonstrating serious mental illness or serious emotional disturbance, as applicable.

CORE ELEMENTS: At the discretion of the single State agency responsible for the administration of the program, the funds may be used to fund some or all of the core crisis care service components, as applicable and appropriate, including the following:

- *Crisis call centers*
- *24/7 mobile crisis services*
- *Crisis stabilization programs offering acute care or subacute care in a hospital or appropriately licensed facility, as determined by such State, with referrals to inpatient or outpatient care.*

STATE FLEXIBILITY: In lieu of expending 5 percent of the amount the State receives pursuant to this section for a fiscal year to support evidence-based programs as required a State may elect to expend not less than 10 percent of such amount to support such programs by the end of two consecutive fiscal years.
A crisis response system has 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. The expectation is that states will build on the emerging and growing body of evidence, including guidance developed by the federal government, for effective community-based crisis-intervention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination, stabilization services to support reducing distress, and the promotion of skill development and outcomes, all towards managing costs and better investment of resources.
Several resources exist to help states. These include ***Crisis Services: Meeting Needs, Saving Lives****, which consists of the* ***National Guidelines for Behavioral Health Coordinated System of Crisis Care*** *as well as an* ***Advisory: Peer Support Services in Crisis Care*** *There is also the* ***National Guidelines for Child and Youth Behavioral Health Crisis Care*** *which offers best practices, implementation strategies, and practical guidance for the design and development of services that meet the needs of children, youth, and their families experiencing a behavioral health crisis. Please note that this set aside funding is dedicated for the core set of crisis services as directed by Congress. Nothing precludes states from utilizing more than 5 percent of its MHBG funds for crisis services for individuals with serious mental illness or children with serious emotional disturbances. If states have other investments for crisis services, they are encouraged to coordinate those programs with programs supported by the 5 percent set aside. This coordination will help ensure services for individuals are swiftly identified and are engaged in the core crisis care elements.*

When individuals experience a crisis related to mental health, substance use, and/or homelessness (due to mental illness or a co-occurring disorder), a no-wrong door comprehensive

crisis system should be put in place. Based on the National Guidelines, there are three major components to a comprehensive crisis system, and each must be in place in order for the system to be optimally effective. These three-core structural or programmatic elements are: Crisis Call Center, Mobile Crisis Response Team, and Crisis Receiving and Stabilization Facilities.

Crisis Contact Center. *In times of mental health or substance use crisis, 911 is typically called, which results in police or emergency medical services (EMS) dispatch. A crisis call center (which may provide text and chat services as well) provides an alternative. Crisis call centers should be made available statewide, provide real-time access to a live crisis counselor on a 24/7 basis, meet National Suicide Prevention Lifeline operational guidelines, and serve as "Air Traffic Control" to assess, coordinate, and determine the appropriate response to a crisis. In doing so, these centers should integrate and collaborate with existing 911 and 211 centers, as well as other applicable call centers, to ensure access to the appropriate level of crisis response. 211 centers serve as an entry point to crisis services in many states and provide information and referral to callers on where to obtain assistance from local and national social services, government agencies, and non-profit organizations.*

The public has become accustomed to calling 911 for any emergency because it is an easy number to remember, and they receive a quick response. Many of the crisis systems in the United States continue to use 911 for several reasons such as they are still building their crisis systems or because they have no mechanism to fund a call center separate from 911. However, they recognize that the sure way to minimize the involvement of law enforcement in a behavioral health crisis response is to divert calls from 911. There are basically three diversion models in operation at this time: (1) the 911-based system with dispatchers who forward calls to either law enforcement's responder team (law enforcement officer with a behavioral health professional) or to their Crisis Intervention Team (CIT) with law enforcement officers who have received Crisis Intervention Training, including awareness of mental health and substance use disorders, and related symptoms, de-escalation methods, and how to engage and connect people to supportive services; (2) the 911-based system with well-trained 911 dispatchers who triage calls to state or local crisis call centers for individuals who are not a threat to themselves or others; the call centers may then refer appropriate calls to local mobile response teams (MRTs), also called mobile crisis teams (MCTs); and (3) State or local Crisis Contact Centers with well-trained counselors who receive calls directly (without utilizing 911 at all) on their own toll-free numbers.

Mobile Crisis Response Team. *Once a behavioral health crisis has been identified and a crisis line has been called, a mobile response may be required if the crisis cannot be resolved by phone alone. Historically, law enforcement has been dispatched to the location of the individual in crisis. But in an effective crisis system, mobile crisis teams, including a licensed clinician, should be dispatched to the location of the individual in crisis, accompanied by Emergency Medical Services (EMS) or police only as warranted. Ideally, peer support professionals would be integrated into this response. Assessment should take place on site, and the individual should be connected to the appropriate level of care, if needed, as deemed by the clinician and response team.*

Crisis Receiving and Stabilization Facilities. *In a typical response system, EMS or police would transport the individual in crisis either to an ED or to a jail. Crisis Receiving and Stabilization Facilities provide a cost-effective alternative. These facilities should be available to accept individuals by walk-in or drop-off 24/7 and should have a "no wrong door" policy that supports all individuals, including those who need involuntary services. When anyone arrives, including law enforcement or EMS who are dropping off an individual, the hand-off should be "warm" (welcoming), timely and efficient. These facilities provide assessment for, and treatment of mental health and substance use crisis issues, including initiating medications for opioid use disorder (MOUD), and also provide wrap-around services. The multi-disciplinary team, including peers, at the facility can work with the individual to coordinate next steps in care, to help prevent future mental health crises and repeat contacts with the system, including follow-up care.*

Currently, the 988 Suicide and Crisis Lifeline (Lifeline) connects with local call centers throughout the United States. Call center staff is comprised of individuals who are trained to utilize best practices in handling behavioral health calls. Local call centers automatically engage in a safety assessment for every call; if an imminent risk exists and cannot be deescalated, they forward the call to either 911 or to a local mobile crisis team for a response. If there is no imminent risk, the call center will work with the individual (or the person calling on their behalf) for as long as needed or, if necessary, dispatch a local MRT.

988 – 3-Digit behavioral health crisis number. *The National Suicide Hotline Designation Act (**P.L. 116-172**) provides an opportunity to support the infrastructure, service and long-term funding for community and state 988 response, a national 3-digit behavioral health crisis number that was approved by the Federal Communications Commission in July 2020. In July 2022, the National Suicide Prevention Lifeline transitioned to 988 Suicide & Crisis Lifeline, but the 1-800-273-TALK is still operational and directs calls to the Lifeline network. The 988 transition has supported and expanded the Lifeline network and will continue utilizing the life-saving behavioral health crisis services that the Lifeline and Veterans Crisis Line centers currently provide.*

Building Crisis Services Systems. *Most communities across the United States have limited, but growing, crisis services, although some have an organized system of services that provide on-demand behavioral health assessment and stabilization services, coordinate and collaborate to divert from jails, minimize the use of EDs, reduce hospital visits, and reduce the involvement of law enforcement. Those that have such systems did not create them overnight, but it involved dedicated individuals, collaboration, considerable planning, and creative methods of blending sources of funding.*

1. Briefly narrate your state's crisis system. For all regions/areas of your state, include a description of access to the crisis call centers, availability of mobile crisis and behavioral health first responder services, utilization of crisis receiving and stabilization centers.

Washington's crisis system is operated at the regional level based on a framework overseen by HCA. HCA contracts with seven regional Behavioral Health Administrative Organizations (BH-ASOs) in ten regions. The BH-ASOs in each region contract with behavioral health agencies to operate mobile crisis, regional crisis lines, and crisis stabilization units. Washington passed a line tax 988 in 2021 and set out a plan to implement 988 and elements of SAMHSA's best practices. With the passage of this legislation planning work has been ongoing to implement a technology solution to coordinate the crisis system. The legislation also created the Crisis Response Improvement Strategy (CRIS) committee that has 36 members to guide implementation of the crisis system improvements.

988 is available statewide covered by 3 contact centers in the state. Each region has a regional crisis line that is separate from 988 at this time and is the primary contact center in a region for access to the crisis system. Work is underway to bring these regional lines in alignment with 988.

There is currently a youth and adult mobile crisis team in each region of the state. The state as a whole is working to expand mobile crisis to improve response times across the state. Recent investments have added 14 new youth teams, and an additional round of investment will allow the state to expand further. Washington is undergoing crisis system enhancements to include mobile crisis team expansion, implementation of SAMHSA national best practices, and improvement of mobile crisis by investing in the ability to transport and standardize training through an endorsement process. Washingtons Medicaid State Plan allows for teams to provide follow up care and in-home stabilization services across the lifespan. Mobile crisis teams respond in a dyad of a clinician and peer. Peers can encounter both crisis intervention and crisis stabilization to support engagement and follow up support.

Washington has a crisis stabilization unit in 8 out of 10 regions in the state with plans to add more facilities in the state. A recent round of capital funds has allocated funding for 6 more facilities in the state. Washington does have some crisis receiving centers in the state, but recently passed legislation will make implementing them easier and standardized. The new rules for facilities will improve access to crisis relief centers.

2. In accordance with the guidelines below, identify the stages where the existing/proposed system will fit in.

> ***a) The Exploration stage: is the stage when states identify their communities' needs, assess organizational capacity, identify how crisis services meet community needs, and understand program requirements and adaptation.***
>
> ***b) The Installation stage: occurs once the state comes up with a plan and the state begins making the changes necessary to implement the crisis services based on the***

SAMHSA guidance. This includes coordination, training and community outreach and education activities.

c) Initial Implementation stage: occurs when the state has the three-core crisis services implemented and agencies begin to put into practice the SAMHSA guidelines.

d) Full Implementation stage: occurs once staffing is complete, services are provided, and funding streams are in place.

e) Program Sustainability stage: occurs when full implementation has been achieved, and quality assurance mechanisms are in place to assess the effectiveness and quality of the crisis services.

Other program implementation data that characterizes crisis services system development.

- ***1. Someone to talk to: Crisis Call Capacity***
  - ***a. Number of locally based crisis call Centers in state***
    - ***i. In the 988 Suicide and Crisis lifeline network***
    - ***ii. Not in the suicide lifeline network***
  - ***b. Number of Crisis Call Centers with follow up protocols in place***
  - ***c. Percent of 911 calls that are coded as BH related***
- ***2. Someone to respond: Number of communities that have mobile behavioral health crisis mobile capacity (in comparison to the total number of communities)***
  - ***a. Independent of first responder structures (police, paramedic, fire)***
  - ***b. Integrated with first responder structures (police, paramedic, fire)***
  - ***c. Number that employs peers***
- ***3. Safe place to go or to be:***
  - ***a. Number of Emergency Departments***
  - ***b. Number of Emergency Departments that operate a specialized behavioral health component***
  - ***c. Number of Crisis Receiving and Stabilization Centers (short term, 23-hour units that can diagnose and stabilize individuals in crisis)***

a. Check one box for each row indicating state's stage of implementation *(Mark "X" in the appropriate line and row, the Block Grant team will check the box on the application.)*

	Exploration Planning	Installation	Early Implementation Less than 25% of counties	Partial Implementation About 50% of counties	Majority Implementation At least 75% of counties	Program Sustainment
Someone to talk to						X
Someone to respond					X	

Safe place to go or to be					X	

3. Briefly explain your stages of implementation selections here.

Washington has fully implemented and staffed its 988 contact centers. We are still implementing new standards and expanding someone to respond category with plans to add more teams in the next few years as funding and workforce allow. The “safe place to go or to be” is still under development. We are expanding facilities and implementing crisis relief centers, but most are still under construction. For a “safe place to be” we are expanding the Mobile Response and Stabilization Services (MRSS) model in the state by implementing youth focused crisis response teams who provide in-home stabilization.

4. Based on SAMHSA's National Guidelines for Behavioral Health Crisis Care, explain how the state will develop the crisis system.

Washington State has passed comprehensive legislation in the past few years to implement SAMHSA’s best practices in the state. Key components of this legislation include the creation of the Crisis Response Improvement Strategy committee to make recommendations on how to implement changes to the crisis system. It also laid out criteria for a technology platform to be used by 988 hubs. It also created the first in the country requirements for fully funded commercial plans to make next day appointments available to their enrollees.
Washington has invested heavily in the crisis system. The state has worked to expand and standardize crisis response and facilities in the state adding 17 new teams in 2022 to ensure there is one team per region. New program standards have been implemented, and data collection mechanisms are being implemented. The state has also worked to implement more crisis stabilization units working to add 10 more across the state.

In the spring of 2023, the state passed legislation which contains requirements for more standards for mobile crisis response and an emphasis on regional analysis of needs. The legislation seeks to improve in-person responses with the creation of the endorsement program. This program creates endorsed mobile rapid response crisis team (MRRCT) and establishes a new type of team, community-based crisis teams (CBCT). Endorsed teams meet state standards for staffing, training, and transportation ensuring they maintain the capacity to respond quickly and effectively to the most acute calls received by 988 Suicide & Crisis Lifeline. The Endorsement Program aims to enhance the statewide behavioral health crisis response system and ensure individuals experiencing a crisis have access to help easily in their regions. We are currently in the final stages of endorsing our first cohort of 8 providers across seven regions and have accepted applications for our second cohort which includes 6 providers from four regions, targeted for endorsement by January 2026.

4. Briefly describe the proposed/planned activities utilizing the 5 percent set aside.

Washington is substantially expanding mobile crisis outreach services including child/youth teams on a statewide basis. Recently passed legislation will improve availability of crisis relief centers, mobile crisis, and community-based crisis intervention and stabilization services in the state with a goal of response times almost on par with other first responders. Block grant 5% set aside crisis funding is used to augment the statewide crisis system, primarily distributed through our Behavioral Health Administrative Service Organizations (BH-ASOs) for use within their regions. Additionally, HCA will use some of the funding to provide state sponsored trainings for Designated Crisis Responders.

We will also provide funding to Washington Tribes for crisis treatment services and the tribal crisis coordination hub:

- Support for a tribal crisis coordination hub:
- Help crisis providers place clients at appropriate inpatient treatment facilities or connect clients with appropriate intensive outpatient treatment;
- Compile and submit crisis reports and data to the state's data store;
- Provide training and support to crisis providers, and effective coordination of care and discharge planning for American Indian and Alaska Native (AI/AN) clients receiving crisis treatment;
- Non-Medicaid crisis treatment services provided by tribal and other Indian health care providers; and
- Capacity building efforts to enable tribal and other Indian health care providers to offer effective crisis services to AI/AN clients, with support for care coordination and transition planning for clients who have experienced crisis.

5. Other program implementation data that characterizes crisis services system development.

Someone to contact: Crisis Contact Capacity

a. Number of locally based crisis call centers in state
    i. In the 988 Suicide and Crisis lifeline network: __3___
    ii. Not in the suicide lifeline network: __10_
b. Number of Crisis Call Centers with follow up protocols in place
    i. In the 988 Suicide and Crisis lifeline network: ___3__
    ii. Not in the suicide lifeline network: __10___
c. Estimated percent of 911 calls that are coded out as BH related: ____10%_

Someone to respond: Number of communities that have mobile behavioral health crisis mobile capacity (in comparison to the total number of communities)

a. Independent of public safety first responder structures (police, paramedic, fire): _39 counties_
b. Integrated with public safety first responder structures (police, paramedic, fire): __18 counties_

c. Number that utilizes peer recovery services as a core component of the model: ___39 counties _

Safe place to be

a. Number of emergency departments:___102_
b. Number of emergency departments that operate a specialized behavioral health component: ___unknown. This is not tracked at any level_
c. Number of crisis Receiving and Stabilization Centers (short term, 23-hour units that can diagnose and stabilize individuals in crisis: __1__

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

None at this time.

Recovery

Recovery supports and services are essential for providing and maintaining comprehensive, quality behavioral health care. The expansion in access to; and coverage for, health care drives the promotion of 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 health and substance use disorders.

Recovery is supported through the key components of health (access to quality physical 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 a recovery- guided approach to person-centered care is inclusive of shared decision-making, culturally welcoming and sensitive to social needs of the individual, their family, and communities. Because mental and substance use disorders can be chronic relapsing conditions, long term systems and services are necessary to facilitate the initiation, stabilization, and management of recovery and personal success over the lifespan.

The following working definition of recovery from mental and/or substance use disorders has stood the test of time:

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

In addition, there are 10 identified 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 **Working Definition of Recovery.***

*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 several federally supported national technical assistance and training centers. States are strongly encouraged to take proactive steps to implement and expand recovery support services and collaborate with existing RCOs and RCCs. Block Grant guidance is also available at the **Recovery Support Services Table**.*

Because recovery is based on the involvement of peers/people in recovery, their family members and caregivers, SMHAs and SSAs should engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing organizations and direct resources for enhancing peer, family, and youth networks such as RCOs and RCCs 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 behavioral health 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

b) Required peer accreditation or certification?

Yes

c) Block grant funding of recovery support services?

Yes

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

2. Does the state measure the impact of your consumer and recovery community outreach activity?

Yes

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

Recovery Support Services for adults with SMI

Foundational Community Supports (FCS): For Medicaid-enrolled individuals, Washington's Foundational Community Supports (FCS) program offers two comprehensive supportive housing and supported employment services for program enrollees. Since launching FCS in 2018, the program has served over 50,000 individuals across Washington state across 240+ providers working over 500 sites.

- FCS Supportive Housing: Serving individuals age 16+ Pre-tenancy services aim to link enrollees with long-term housing opportunities. Tenancy sustaining services aim to link tenants with resources in their community that help stabilize and sustain their housing.
- FCS Supported Employment: Serving individuals aged 18+ Pre-employment services aim to link enrollees with sustainable employment. Employment sustaining services link enrollees with resources to bolster their job stability and security.

Housing and Recovery through Peer Services (HARPS): This program is available to individuals with a substance use disorder who are exiting or at risk of entering inpatient behavioral health programs who do not have access to Medicaid, and who also experience housing instability. HARPS provides pre-tenancy and tenancy sustaining services to individuals. HARPS also includes a short-term bridge subsidy to assist with rent, deposits, application fees etc.

Projects for Assistance in Transition from Homelessness (PATH): a long-standing program designed to outreach and assist eligible individuals to access supportive services, basic needs resources and connection to care. Services include housing resources, systems and benefits coordination, mental health care, substance use treatment, disability support, and other services to enable enrollees to move toward their goals. PATH is administered by the Center for Mental Health Services, a component of the Administration for Healthy America, AHA, within the US Department of Health and Human Services. This includes Twelve (12) agencies across all

regions. FY23-25 total enrolled (1,387), 72% of enrollees were persons homeless with serious mental illness and 835 of the PATH enrollees were connected to community mental health services.

Peer Support Services: Since 2005, Washington has trained and qualified individuals with lived experience in behavioral health who identify as being in recovery, and parents or legal guardians of a person who has applied for, is eligible for, or has received behavioral health services as certified peer counselors. Peer specialists work with youth, adults, and/or parents/guardians of children receiving behavioral health services. Peer supporters draw upon their experiences to inspire individuals to find hope and make progress toward recovery through shared understanding, rapport, and empowerment. Peer supporters assist individuals in identifying goals and working towards meeting their goals, overcome barriers, build community and relationships, share resources, and build skills. Peer services increase empowerment, champion hope, and promote the expectation that recovery is possible for everyone.

Peer Bridger: The program pairs individuals currently hospitalized with Certified Peer Specialists: individuals with lived experience of Behavioral Health recovery who offer understanding, encouragement, and support from a place of shared experience. Peer Bridgers build relationships with individuals prior to discharge, providing emotional support, recovery education, and hope. After discharge, they continue to offer peer support services to help individuals navigate outpatient services, secure housing or employment, and build support networks while promoting dignity and empowerment.

Recovery Support Services for children with SED

Youth and Family Peers: Family Peer Partner and Youth Peer Partner development in services and system development. This includes the Substance Use Disorder Education and Curriculum program, which equips families and friends who love a young person with SUD, skills and information to support healthy choices and set realistic expectations for their family system. In addition, Washington state supports six SUD Family Navigator sites, which provide a menu of services for family members with resources on how to engage their loved ones with SUD. These critical services allow families to focus on their own selfcare and wellness, while seeking ways to encourage recovery efforts within their family system.

To better serve the Transition Age Youth (18-25 years) population, HCAs supported Collegiate Recovery Support program, which provide students recovering or seeking recovery from substance use the opportunities that higher education offers in a supportive college environment. These programs provide support and positive community connections, prevent a return to substance use, and promote successful academic performance

Center for Parental Excellence (COPE) project was developed as a support to enhance our System of Care framework. The project is intended to provide a pathway for Washington State parents who are accessing and navigating the children's behavioral health system to have peer support to ease their journey, whenever possible. This peer support allows parent/caregivers to have mentoring and coaching, by a parent with lived experience, to ensure that the needs of the family are captured in all treatment and planning processes for their families, as it is important that when families ask for help, they feel as though they received the help they asked for.

Youth & Young Adult Housing Response Team (YYAHRT), led by the Department of Children, Youth & Families, that youth shall be discharged into safe and stable housing. YYAHRT brings all pertinent stakeholders and community members to team meetings centered around youth voice and choice. This gives families and young people an opportunity to not only discuss potential housing options but to speak directly with their managed care organization and community providers to gain support connecting to behavioral health services, such as making appointments, or to coordinate services within the community. YYAHRT also holds weekly lunch conferences where a community member, family/caregiver, or agency can receive direct technical assistance.

The WA State Children's Behavioral Health Statewide Family Network was developed to ensure a dedicated space for parents to share their lived experience with the behavioral health system, identify themes and work to bring their voices of lived experience to the system that serves them. They host an annual Parent Training Weekend; this is a dedicated space for parents/caregivers and is free to all parents/and caregivers. They also host an annual Behavioral Health Summit which is open to parents/caregivers, youth and system partners. They have workgroups and subcommittees to make recommendations to the system based on their lived experience.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.

PEER SUPPORT

Peer Support Services: Peer specialists work with youth, adults, and/or parents/guardians of children receiving behavioral health services. Peer supporters draw upon their experiences to inspire individuals to find hope and make progress toward recovery through shared understanding, rapport, and empowerment. Peer supporters assist individuals in identifying goals and working towards meeting their goals, overcome barriers, build community and relationships, share resources, and build skills.

To support the peer workforce, HCA provides certified peer support specialist trainings.

In Fiscal Year, HCA offered 134 trainings resulting in 2,091 people trained as Certified Peer Counselors. Out of the 2,091 people trained, 1,015 of them identify as either having substance use or co-occurring recovery. The Peer support program has 90 trainings scheduled for FY2025, with a total of 1,437 people trained as of May 2025 and 665 of them identify either having substance use or co-occurring recovery.

Peer Bridger Program: Certified Peer Counselors (CPCs) serve individuals transitioning from inpatient and/or residential settings to lower levels of care by providing peer support, discharge planning, and goal setting during the transition process. To date, this program has supported 154 individuals.

Clubhouse and Peer-Run Organizations: As individuals reengage in friendship, family, employment, and education, they may need continued support and resources during their recovery. Clubhouse and Peer-Run Organizations provide recovery community environments for people who need the support of others to reach their own vision of recovery.

As of July 2024, the Clubhouses and Peer-run Program consist of 42 providers/ locations (12 Clubhouses, 14 Recovery Community Organizations, 14 Recovery Cafes and 1 Tribal -Alternative Promising Practice). Service outcomes for SFY24 Number of enrollments: 9,584, basic needs assistance: 13,629, employment services: 3,243, educational services: 8,250, and average daily attendance: 4,635.

RECOVERY HOUSING

Oxford Houses: A democratically self-governed and self-supported drug-free house for people in recovery from substance use disorder. 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 House Washington boasts one of the largest numbers of Oxford Houses in the country with sites in 23 of the 39 counties within the state. As of April 2025, we have 368 Oxford Houses and 3,264 beds available daily.

- Total Women's Houses: 105
- Total Houses for Women with Children: 42
- Total of Men's Houses: 263
- Total Houses for Men with Children: 25

Recovery Residences: The Substance Abuse and Mental Health Services Administration (SAMHSA) defines recovery residences/homes as safe, healthy, family-like, substance-free living environments that support individuals in recovery from substance use disorder (SUD).

As of April 2025, the Washington Alliance for Quality Recovery Residences (WAQRR) has accredited 233 homes that have been approved to be on the HCA Recovery Residence Registry. There are currently 1,700 recovery residence beds in Washington state within these 233 accredited houses. WAQRR continues to provide technical assistance to new and established recovery residences to include in-person and virtual training, webinars, and fidelity reviews. Out of the 233 homes, Washington registry of recovery homes includes:

- 138 Men's homes
- 46 Women's homes
- 37 Family homes
- 2 Shared family homes
- 10 Co-Ed homes

In May of 2023, the Washington State legislature appropriated funding for HCA to provide operating grants for newly established Recovery Residences who require more support than a level 1 residence (Oxford House). This additional support enabled the state to add 131 homes accredited level 2 recovery residences in 14 of our 39 counties and 7 of our 8 service regions.

In total, we have a grand total of 601 recovery residences (level 1 and 2) with 4,764 beds available on a daily basis. We are committed to expanding opportunities for recovery housing through supporting the growth of Oxford Homes across Washington and with the continued funding of operating grants for newly established recovery residences.

OUTREACH/ENGAGEMENT

Projects for Assistance in Transition from Homelessness (PATH): Designed to assist eligible individuals to access supportive services, basic needs resources and connection to care, PATH services include housing resources, systems and benefits coordination, mental health care, substance use treatment, disability support, and other services to enable enrollees to move toward their self-determined goals.

Peer Pathfinder: Builds on the already established "Projects for Assistance in Transition from Homelessness" (PATH) Peer Pathfinder expands services to persons experiencing a substance use disorder (SUD) this includes peer support in emergency rooms and homeless encampments. The project links individuals to treatment options including Medication for Opioid Use Disorder (MOUD).

Peer Pathfinder teams consist of two peer counselors who assist individuals in navigating and obtaining services to address barriers to independence and recovery. These services address housing, financial resources, transportation, habilitation and rehabilitation services.

Homeless Outreach Stabilization and Transition (HOST): Provides outreach-based treatment services to individuals with serious behavioral health challenges including substance use disorder (SUD). Multi-disciplinary teams can provide behavioral health, medical, rehabilitative, and peer services in the field to individuals who lack consistent access to these vital services.

In SFY 24, HOST Teams statewide served 2,909 unique individuals, providing a total of 12,357 service encounters. The services provided include: 1,669 medical, 2,466 SUD, 714 mental health, 4,521 peer support, and 952 with a prescriber.

SUPPORTIVE HOUSING & SUPPORTED EMPLOYMENT

Foundational Community Supports (FCS): For Medicaid-enrolled individuals, Washington's Foundational Community Supports (FCS) program offers two comprehensive supportive housing and supported employment services for program enrollees. Since launching FCS in 2018, the program has served over 50,000 individuals across Washington state across 240+ providers working over 500 sites.

- FCS Supportive Housing: Pre-tenancy services aim to link enrollees with long-term housing opportunities. Tenancy sustaining services aim to link tenants with resources in their community that help stabilize and sustain their housing.

- FCS Supported Employment: Pre-employment services aim to link enrollees with sustainable employment. Employment sustaining services link enrollees with resources to bolster their job stability and security.

Housing and Recovery through Peer Services (HARPS): This program is available to individuals with a substance use disorder who are exiting or at risk of entering inpatient behavioral health programs who do not have access to Medicaid, and who also experience housing instability.

Passageways to Recovery Employment and Education (PREE): The Washington State Legislature appropriated funding for HCA to establish a grant program that provides employment, education, training, certification and other supportive services designed to decrease barriers for persons recovering from a substance use disorders. Since inception PREE has served (1,311) individuals and approximately 50% have either started employment or education tracks. A total of 935 people received barrier removal funds and 269 received education funds.

Short-term housing vouchers to support people with substance use disorders (SUD): The SUD housing vouchers are focused on serving the five most populous counties in the state. Since inception approximately (1,351) people have either gained housing or were diverted from homelessness. HCA utilizes state funds appropriated to provide short term housing vouchers for people living at a level 1 (Peer Run) or level 2 (Monitored) recovery residences.

5. Does the state have any activities that it would like to highlight?

DBHR has developed robust Recovery Support Services within Washington state including:

- Expansive peer support specialists and training to support providers in operationalizing peer support services in their programs.
- Supported employment services that link individuals in recovery with sustainable education, training, and employment opportunities.
- Recovery housing to support individuals transitions from treatment, or homelessness, back into their communities.
- Recovery coordination for individuals in transition from state hospitals back to community living.

- Recovery support services for individuals with co-occurring, including outreach and engagement.
- Continued recovery supports within communities including ongoing case management services, coordination, and connection for people with substance use disorder and/or mental health diagnoses, and complex physical health needs.

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 Certified Peer Specialists in various environments on the behavioral health and physical health services continuum.

Children and Adolescents M/SUD Services – Required for MHBG

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SUPTRS BG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health disorder and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.[1] Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.[2] For youth between the ages of 10 and 14 and young adults between the ages of 25 and 34, suicide is the second leading cause of death and for youth and young adults between 15 and 24, the third leading cause of death.[3]

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started using substances the age of 18. Of people who started using substances before the age of 18, one in four will develop a substance use disorder compared to one in 25 who started using substances after age 21.[4]

Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one

specialized system, including mental health, substance use, 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, states are encouraged to designate a point person for children to assist schools in assuring identified children relate to available prevention services and interventions, mental health and/or substance use screening, treatment, and recovery support services.

Since 1993, the federally funded Children's Mental Health Initiative (CMHI) has been used as an approach to build the system of care model 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, states have also received planning and implementation grants for adolescent and transition age youth SUD and MH treatment and infrastructure development. This work has included a focus on formal partnership development across child serving systems and policy change related to 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 functioning of children, youth and young adults in home, school, and community settings. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult, and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.[5]

According to data from the 2017 Report to Congress on systems of care, services reach many children and youth typically underserved by the mental health system.

1. improve emotional and behavioral outcomes for children and youth.

2. enhance family outcomes, such as decreased caregiver stress.

3. decrease suicidal ideation and gestures.

4. expand the availability of effective supports and services; and

5. save money by reducing costs in high-cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

The expectation is that states will build on the well-documented, effective system of care approach. 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:

1. 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);

2. supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and employment); and

3. residential services (e.g., therapeutic foster care, crisis stabilization services, and inpatient medical withdrawal management).

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

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

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

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

*[5]Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from **https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM***

Please respond to the following:

1. Does the state utilize a system of care approach to support:

a) The recovery of children and youth with SED?
Yes

b) The resilience of children and youth with SED?
Yes

c) The recovery of children and youth with SUD?
Yes

d) The resilience of children and youth with SUD?
Yes

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs
a) Child welfare?
Yes

b) Juvenile justice?
Yes

c) Education?
Yes

d) Health Care
Yes

3. Does the state monitor its progress and effectiveness, around:
a) Service utilization?
Yes

b) Costs?
Yes

c) Outcomes for children and youth services?
Yes

4. Does the state provide training in evidence-based:
a) Substance use prevention, SUD treatment and recovery services for children/adolescents, and their families?
Yes

b) Mental health treatment and recovery services for children/adolescents and their families?

Yes

5. Does the state have plans for transitioning children and youth receiving services:
a) to the adult M/SUD system?
Yes

b) for youth in foster care?
Yes

c) Is the child serving system connected with the Early Serious Mental Illness services?
Yes

d) Is the state providing trauma informed care?
Yes

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)
The Family Youth System Partner Round Table (FYSPRT) provides leadership to influence the establishment and sustainability of Children's Behavioral Health principles statewide. The FYSPRTS play a critical role, within the child, youth, young adult, and family behavioral Health Governance Structure, in informing and providing oversight for their communities and legislative-level policymaking, program planning, and decision-making. Regional FYSPRTs serves as a mechanism for ensuring that local community input and the voice of families and youth with lived experience is present, participating in, and informing child, youth and family behavioral health. In alignment with the Children's Behavioral Health Principles, the Statewide and Regional FYSPRTs provide recommendations and strategies to improve behavioral health services, supports, and outcomes for children and youth and inform system transformation as well as review both process and outcome indicators including Wraparound with Intensive Services outcome and performance data.

The 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.

- To date Washington state supports four SUD residential programs, via contracts with each to maintain residential treatment bed capacity. Funds can be used for recruitment and retention of staff, program development and enhancement, and training/education. As part of this contract and partnership, HCA holds quarterly learning collaboratives with the SUD residential programs to ensure both programs and the communities they serve are adequately supported to provide quality and attuned programing. There is also a contract in place to support a fifth SUD residential partner in Summer 2025. This program will focus on serving young people with both SUD and severe psychiatric diagnosis. HCA has continued to identify ways to inform families about these services and in what ways to access them.
- HCA contracts with experts and organizations to offer training and technical assistance opportunities for behavioral health professionals who serve youth. Topics vary and are determined and informed by clinician feedback and community needs. Trainings and projects that have occurred include matching clinical interventions to individual readiness and increasing family engagement.
- 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 a certified peer specialist 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.
- Continued implementation and expansion of Washington State's First Episode Psychosis Initiative through evidence-informed, recovery oriented coordinated specialty care, which in Washington is called New Journeys. New Journeys multidisciplinary teams provide early intervention services for individuals experiencing early onset of schizophrenia spectrum disorders and affective disorders with psychotic features. Services are provided at a higher intensity than regular outpatient care and are curated to meet the individual needs of people experiencing symptoms and their family members. Currently, 18 teams are operational across the State.
- Family Peer Partner and Youth Peer Partner development in services and system development. This includes the Substance Use Disorder Education and Curriculum program, which equips families and friends who love a young person with SUD, skills and information to support healthy choices and set realistic expectations for their family system. In addition, Washington state supports six SUD Family Navigator sites, which provide a menu of services for family members with resources on how to engage their loved ones with SUD. These critical services allow families to focus on their own selfcare and wellness, while seeking ways to encourage recovery efforts within their family system.
- To better serve the Transition Age Youth (18-25 years) population, HCAs supported Collegiate Recovery Support program, which provide students recovering or seeking recovery from substance use the opportunities that higher education offers in a supportive college environment. These programs provide support and positive community connections, prevent a return to substance use, and promote successful academic performance

- 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 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 Youth and Young Adult Continuum of Care Subcommittee of the Children's Behavioral Health Workgroup, the Statewide FYSPRT, and ten Regional FYSPRTs. The Statewide FYSPRT has a tribal representative and representatives from youth and young adult serving state partners: Department of Children, Youth and Families (DCYF), which now includes Juvenile Rehabilitation (JR) and the Department of Early Learning (DEL), Department of Health (DOH),), Department of Health and Human Services (DSHS), Office of Superintendent of Public Instruction (OSPI), Developmental Disabilities Administration (DDA), Commerce, and Managed Care Organizations.

Block Grant Funding has been used for several years to provide 'no cost' training and follow-up coaching to clinicians in Cognitive Behavioral Therapy Plus (CBT+). The dollars continue to support this work while in tandem developing a train-the-trainer model with the intention of placing local trainers in each Behavioral Health Organization to further grow the workforce. The System of Care Grant enhanced EBT training in Washington by providing DBT skills training for clinicians and peers on mobile response team. Training has also been developed to support clinicians/providers working with family members who support a loved one with SUD. Community Reinforcement and Family Training (CRAFT) is an EBP that supply family members skills to engage their loved one into treatment. CRAFT is especially effective for parents who has a young person actively using substances in the home. Trainings for clinicians/providers were held virtually in April, May, and June of 2025.

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. 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 Use Prevention and Treatment Recovery Services block grant funds are awarded annually to regional Educational Service Districts. The Student Assistance Prevention Intervention Services program places Student Assistance Specialists in schools in Community Prevention and Wellness Initiative locations to address problems associated with substance use violence and other non-academic barriers to learning.

Student Assistance Specialists (SAP) are assigned to designated school sites to provide direct services to students who are at risk and/or harmfully involved with alcohol, tobacco, and other drugs. SAP services include:

- Administer a uniform screening instrument to determine levels of substance use and mental health concerns.
- Individual and family counseling and interventions on student substance use.

- Peer support groups to address student and/or family substance use issues.
- Coordinate and make referrals to treatment and other social service providers; and,
- School-wide prevention activities that promote healthy messages and decrease substance use

7. Does the state have any activities related to this section that you would like to highlight?
(Please see above)

8. Please indicate areas of technical assistance needed related to this section.
None at this time.

Suicide Prevention

Suicide is a major public health concern, it is a leading cause of death nationally, with over 49,000 people dying by suicide in 2022 in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance use, painful losses, exposure to violence, economic and financial insecurity, and social isolation. Mental illness and substance use are possible factors in 90 percent of deaths by suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, M/SUD agencies are urged to lead in ways that are suitable to this growing area of concern. M/SUD agencies are encouraged to play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following:

1. Have you updated your state's suicide prevention plan in the last 2 years?

Yes, the Washington State Suicide Prevention Plan was updated and published in May of 2025. This effort is led by the Washington State Department of Health.

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. Community-based organizations (CBOs) are state grant funded organizations that serve communities by providing high-quality substance use disorder prevention, mental health promotion and suicide prevention programming through evidence-based, research-

based, and innovative programs and strategies. CBOs include, but are not limited to, non-profits, faith-based organizations, educational service districts, schools, tribal or local governmental entities. CBOs are focused on the delivery of prevention and promotion programs and/or strategies to meet a targeted need. Such programs can include mentoring, parenting education, community awareness raising, training, and youth skill building.

CBOs and the programs they organize can support the larger Community Prevention and Wellness Initiative (CPWI) or other local or regional community coalitions of Washington State. Through partnerships like this, CBOs can help expand the reach of a coalition and build off their strategic plan. Alternately, CBOs can operate independently, providing targeted prevention and promotion programming to meet a need that organization has identified.

3. Have you incorporated any strategies supportive of Zero Suicide?

Yes, HCA developed a suicide care pathway based on the Zero Suicide toolkit and the Spectrum of Mental, Emotional, Behavioral Health Interventions to address services and programs through promotion, prevention, treatment, and maintenance. It was published and disseminated in 2024 for prevention, treatment, and community members.

4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments?

No

5. Have you begun any targeted or statewide initiatives since the FFY 2024 - 2025 plan was submitted?

No

If so, please describe the population targeted?

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

None at this time.

Support of State Partners

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

- *The State Medicaid Authority agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations.*
- *The state 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 prioritize risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of M/SUD, 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 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 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.*
- *The state's agency on aging which provides chronic disease self-management and social services critical for supporting recovery of older adults with M/SUD.*
- *The state's intellectual and developmental disabilities agency to ensure critical coordination for individuals with ID/DD and co-occurring M/SUD.*

- *Strong partnerships between SMHAs and SSAs and their counterparts in physical health, public health, and Medicaid, Medicare, state, and area agencies on aging and educational authorities are essential for successful coordinated care initiatives. While the State Medicaid Authority (SMA) is often the lead on a variety of care coordination initiatives, SMHAs and SSAs are essential partners in designing, implementing, monitoring, and evaluating these efforts. SMHAs and SSAs are in the best position to offer state partners information regarding the most effective care coordination models, connect current providers that have effective models, and assist with training or retraining staff to provide care coordination across prevention, treatment, and recovery activities.*
- *SMHAs and SSAs can also assist the state partner agencies in messaging the importance of the various coordinated care initiatives and the system changes that may be needed for success with their integration efforts. The collaborations will be critical among M/SUD entities and comprehensive primary care provider organizations, such as maternal and child health clinics, community health centers, Ryan White HIV/AIDS CARE Act providers, and rural health organizations. SMHAs and SSAs can assist SMAs with identifying principles, safeguards, and enhancements that will ensure that this integration supports key recovery principles and activities such as person-centered planning and self-direction. Specialty, emergency and rehabilitative care services, and systems addressing chronic health conditions such as diabetes or heart disease, long-term or post-acute care, and hospital emergency department care will see numerous M/SUD issues among the persons served. SMHAs and SSAs should be collaborating to educate, consult, and serve patients, practitioners, and families seen in these systems. The full integration of community prevention activities is equally important. Other public health issues are impacted by M/SUD issues and vice versa. States should assure that the M/SUD system is actively engaged in these public health efforts.*
- *Enhancing the abilities of SMHAs and SSAs to be full partners in implementing and enforcing MHPAEA and delivery of health system improvement in their states is crucial to optimal outcomes. In many respects, successful implementation is dependent on leadership and collaboration among multiple stakeholders. The relationships among the SMHAs, SSAs, and the state Medicaid directors, state housing authorities, insurance commissioners, prevention agencies, child-serving agencies, education authorities, justice authorities, public health authorities, and HIT authorities are integral to the effective and efficient delivery of services. These collaborations will be particularly important in the areas of Medicaid, data and information management and technology, professional licensing and credentialing, consumer protection, and workforce development.*

Please respond to the following items:

1. ***Has your state added any new partners or partnerships since the last planning period?***
   Yes

2. ***Has your state identified the need to develop new partnerships that you did not have in place?***
   Yes

If yes, with whom?

The SSA works closely with statewide organizations and associations that support the provision of behavioral health services, such as the Washington Council for Behavioral Health and the Association of Alcoholism and Addiction Treatment Professionals.

For primary prevention of substance use disorder and mental health promotion, representatives of the SSA serve as co-chair and organizer of the Washington State Prevention Enhancement (SPE) Policy Consortium, which consists of 20+ agencies and organizations focused on reducing behavioral health risk factors and building protective factors at the individual, family, and community levels.

The SSA maintains close relationships with research partners at the University of Washington's Social Development Research Group, and Washington State University's Impact Labs. These two institutions are consistent leaders in national prevention research, and provide valuable advice, training, and evaluation for the SSA's primary prevention activities and programs.

HCA has strengthened our relationship with multiple courts across the state as part of continued outreach and engagement in the Trueblood phased regions to aid court partners in the most efficient ways to access outpatient forensic specialty services and outpatient competency restoration and will continue to provide assistance to additional court partners.

We continue to deepen relationships with our partners in education, justice, disabilities administration, early learning, and child welfare. We support cross agency connection, coordination, and specialty teams working on different aspects of the lifespan to increase coordination, understand needs and systems of our partners, and have moved toward piloting and establishing new work cross agency through state and federal dollars. Additionally, we're focusing on our partnership with our juvenile justice system and access and support through Wrap Around with Intensive Services to support re-entry. We partner with several layers of the educational system to increase access and to pilot access points to learn from and share such as the SAMHSA System of Care grant funded Telehealth for school's playbook.

We began partnering with Washington State Department of Corrections in 2023 to provide certified peer counseling training utilizing state funds. This has resulted in training over 300 incarcerated individuals as certified peer counselors, this has enabled people to exit the prison system with a job skill that can be used to provide Medicaid reimbursable services. The DOC Monroe Corrections Coplen is launching a peer resource program in FY25 that will employ peers who have been trained through the partnership.

HCA, Division of Behavioral Health and Recovery (DBHR) was awarded a three-year, $7,000,000.00, Bureau of Justice Assistance (BJA) grant to implement a comprehensive initiative to address the needs of individuals who use drugs across the Sequential Intercept Model (SIM). This grant is known as the Comprehensive Opioid, Stimulant, and Substance Use Program (COSSUP) grant. DBHR has partnered with the Criminal Justice Training Commission (CJTC) for COSSUP programming under Intercept 1: Law Enforcement. CJTC will conduct a total of (6) trainings under year 1 of the COSSUP grant.

Coordination with WASPC and LEAD Support Bureau

HCA's Division of Behavioral Health and Recovery (DBHR) operates multiple grant programs that support community-based alternatives to jail and prosecution for people whose unlawful behavior stems from unmanaged substance use, mental health challenges, or extreme poverty using the Law Enforcement Assisted Diversion (LEAD) model framework. DBHR partners with the LEAD Support Bureau for the provision of technical assistance to the entities involved with administering or implementing these initiatives. Some of the diversion grant programs are supported directly by HCA staff and operate under the LEAD branding, and DBHR also partners with the Washington State Association of Sheriffs and Police Chiefs (WASPC) and the Criminal Justice Training Center (CJTC) to develop, fund, and coordinate implementation of the Arrest and Jail Alternatives (AJA) program.

3. ***Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilities Education Act.***

The Washington State Health Care Authority works with system partners to deliver services that promote successful transitions to and outcomes in community-based settings. Some examples are as follows.

- HCA contracts with managed care organizations to provide robust care coordination services to ensure clients are successful in community-based settings. MCO care coordinators are required to work closely with clients, providers, and other State agencies to support access to medically necessary state plan services, waiver-based habilitative supports, and state-only funded wrap around services to ensure best possible outcomes for managed care enrolled clients.

- Contractual requirements for MCOs and Behavioral Health Administrative Service Organizations require working as members of the state hospital Discharge Transition Team to identify potential discharge options and resolve barriers to discharge for assigned enrollees.

- Each of the BH-ASOs works with stakeholders across their region to ensure coordination of services and resources. BH-ASOs sponsor monthly/quarterly provider meetings. BH-ASOs and providers participate in community events, and coordinate with the schools to provide outreach and support access to services. The BH-ASOs work with other state agencies including Developmental Disabilities Administration (DDA), Division of Youth and Families, and Home and Aging and Long-Term Services Administration. BH-ASOs also participate in monthly coordination meetings the HCA and bi-monthly coordination meetings with the Managed Care Organizations.

- HCA works closely with our state Department of Commerce, and Department of Social and Health Services to evaluate applicant behavioral health providers for inpatient or residential settings to ensure that their business plans do not constitute an Institute for Mental Disease. This work helps identify agencies that are not reimbursable under federal guidelines, protecting federal dollars, and helps new providers adjust their business plans to appropriately meet the requirements laid forth to maintain small and effective 16-bed facilities when treating those with behavioral health conditions.

- HCA contracts with community-based inpatient settings to provide behavioral health treatment for people on 90- or 180-day involuntary treatment orders. As part of these contracts, HCA expects treatment settings to partner with the MCOs for Medicaid enrollees and BH-ASOs for people without Medicaid or outside of managed care, to assure complete discharge plans are in place for thoughtful transitions to lower levels of care.

- Multi-System Rounds is a weekly meeting that pulls together a comprehensive team of subject matter experts, state agency leaders and Managed care organization clinical staff to assist youth (<21) who are at risk for dependency, institutionalization, or experiencing complex barriers to accessing community-based care.

- The 1580 Rapid Care Team (RCT) is a multidisciplinary, cross-agency initiative to support children and youth in crisis; identified as those under age 18 who are hospitalized without medical necessity or are DCYF dependent and facing placement instability. The

RCT aims to reduce prolonged hospital stays by facilitating coordinated interventions and system-level solutions. The team includes representatives from the Department of Children, Youth, and Families (DCYF), Health Care Authority (HCA), Department of Social and Health Services (DSHS), Office of Financial Management (OFM), and A Common Voice (ACV), The Center of Parent Excellence, all led by the Governor's Office Project Director. Together, these partners work to ensure timely and appropriate transitions, and support the safety, stability, and well-being of children and families impacted by complex behavioral health challenges.

- Kids Mental Health WA Health Care Authority (HCA) is working with Kids' Mental Health Pierce County (KMHPC) and the Developmental Disabilities Administration (DDA) to create Youth Regional Behavioral Health Navigation teams known as Kid's Mental Health WA. The teams aim to enhance communication, streamline service connections, and establish Multidisciplinary Teams (MDT) to better coordinate support for children and youth facing behavioral health challenges. The regional teams will prioritize requests for help from young people who need intensive services. Kids Mental Health Washington is supporting each region by, establishing community-wide teams to assist children, youth, and families in their area; Creating an access portal for individuals concerned about a child or youth to request support; Convening a multi system disciplinary team from the community to identify resources and develop stability plans while resource options are being explored. For the past three years, HCA in partnership with Behavioral Health Administrative Services Organizations, Kids' Mental Health Pierce County, and the Developmental Disabilities Administration, has been setting up three regions per year to implement these services. Technical assistance, support, collaborative learning teams across the state, and avenues for real time input on regional strengths and needs are being developed as these teams are formed.

- Center of Parent Excellence the COPE project was developed as a support to enhance our System of Care framework. The project is intended to provide a pathway for Washington State parents who are accessing and navigating the children's behavioral health system to have peer support to ease their journey, whenever possible. Support is provided by A Common Voice, a statewide, family-run nonprofit organization that provides advocacy and support for families whose children have intensive behavioral health needs. They provide individual peer support to parents/caregivers, as well as regional support groups. They attend system meetings with parents upon request to include school meetings and assist parents to navigate Individuals with Disabilities Education Act. Their Family Lead Support Specialists are also incorporated into the 1580 WA Rapid Care Team's.

- New Journeys New Journeys is a coordinated specialty care model based on Navigate, curated to meet the needs of those in Washington experiencing first episode psychosis. The multidisciplinary team offers a coordinated and specialized approach that targets an individual's unique needs and provides more intensive recovery support when compared to regular outpatient treatment. New Journeys provides outreach and

outpatient intervention for youth and young adults when first diagnosed with psychosis. It's a vital treatment program that allows individuals access to treatment services as soon as they start to experience symptoms, rather than waiting to become severely or chronically ill.

- Referrals can be made in multiple ways. The New Journeys website offers a referral form which can be used to contact New Journeys teams across the state. Each New Journeys team works to form a local referral network and develop an Advisory Committee. An Advisory Committee is comprised of cross-agency partners who serve as liaisons to their larger agency and serve to direct FEP referrals to the New Journeys team. Members may include representatives from various systems in the region, including but not limited to the regional BH-ASO, MCOs, WISe Coordinator(s), allied system/agency partners (schools, youth programming, etc.), individuals with lived experience, and/or natural supports. An Advisory Committee can enhance cross-system collaboration and improve outcomes for youth and young adults through ongoing community education, early identification, and access to early intervention programs. The idea is that someone experiencing FEP should be seen by the team of specialists (e.g. New Journeys) regardless of which agency in a community the person experiencing symptoms seeks services. Complex Discharge process reduces inpatient length of stay by ensuring MCOs are compliant with contract requirements for discharge planning and care coordination, identify and address barriers to discharge and implement solutions, with the goal of minimizing or eliminating discharge barriers. MCOs are required to submit weekly reports on care coordination activities for all clients in the state who are clinically cleared for discharge.

- Cross agency escalation pathways have been established to address cases where there are barriers to individuals being served successfully in community-based settings.

- Intensive residential treatment (IRT) teams work with individuals discharging or diverting from state hospitals or long-term hospitalizations who need wraparound support. The teams help those struggling to remain in community settings such as adult family homes (AFH) or assisted living facilities. IRT teams are the primary mental health provider and use elements from assertive community treatment (ACT) to provide intensive wraparound mental health care to the individual in their facility, helping them transition to a lower level of care.

- Legislatively funded Difficult to Discharge Task Force pilot program is under development.

- HCA participates in DSHS-led client Critical Case Protocol (CCCP) meetings as needed for clients at risk of losing their community-based residential providers due to illegal activity, high utilization of emergency/law enforcement services, housing issues, or increased support needs.

- HCA's School-Based Health Care Services (SBHS) program provides Medicaid reimbursement to schools for evaluations, reevaluations, and direct health related services provided by qualified staff that are included in an eligible student's IEP. Public schools are required per the Individuals with Disabilities Education Act to find and evaluate students who may have disabilities, at no cost to families. If a child has a qualifying disability, schools must offer special education and related services (like speech therapy and counseling) to meet the child's unique needs through an Individualized Education Program (IEP). Schools are not required to participate in the SBHS program; however, participation benefits the entire school population as it brings in additional funding which helps offset costs associated with providing these healthcare related services.

- We support coordination and connection with our state Office of Superintendent of Public Instruction (OSPI) and our Medicaid office. Current conversations are underway to explore the gap between IDEA serving through age 21 and Medicaid EPSDT through age 20. Our legislature is interested in ensuring those supports stay intact while students are in K-12 services.

- We also partner with our Medicaid office and OSPI to identify pathways to support schools seeking to support access for behavioral health for their students, and are exploring areas like peers in schools, and supports for schools to support teachers so they can support students.

- HCA contracts with the child and youth Children's Longterm Inpatient Program (CLIP) that consists of community based Psychiatric Residential Treatment Facilities (PRTF) and the hospital-based Child Study Treatment Center (CSTC) to ensure supports and coordination both prior to admission and as part of discharge coordination to ensure supports for community-based supports and services for the child and family. Additionally, we contract with each program to ensure funding and support for familial/ natural support engagement during treatment in the CLIP program.

- Apple Health and Homes is a multi-agency effort between the HCA, Washington State Department of Social and Health Services and Washington State Department of Commerce that pairs healthcare services with housing resources for some of the state's most vulnerable residents. Apple Health and Homes aligns health care and housing for individuals with complex needs by combining the acquisition and development of permanent supportive housing (PSH) with community support services (CSS).

- The Youth & Young Adult Housing Response Team (YYAHRT) is a cross-agency collaborative effort spearheaded by the Department of Children, Youth & Families (DCYF) that works to ensure young people exiting from Systems of Care are released to safe and stable housing. YYAHRT brings state agencies such as the Office of Homeless Youth (OHY), the Developmental Disabilities Administration, Health Care Authority, in addition to McKinney Vento liaisons', Child welfare and Juvenile Rehabilitation and

community behavioral health providers to ensure young people have all the supports necessary to maintain stability.

- The Bridge Coalition contract administered by NorthStar Advocates is a committee of young people, discharge planners, housing providers and community behavioral health provider to discuss current legislation, training on best practices, consultation with providers and the creation of return to community plans to ensure young people have better outcomes within their communities. These collaborative efforts informed legislation to develop and implement the Post Inpatient Behavioral Health Facility (IBHTF) Transitional Housing Program (HB 1929, The Bridge Housing). The Post IBHTF transitional housing program is for young adults 18 through 24 who have completed treatment and are in need housing and behavioral health support. This program is located on the East and West side of the Cascade Range. The Washington State Department of Social and Health Services works to support discharges to home and community, and delivers community based, person-centered services in community-based settings, including the following.

- The Developmental Disabilities Administration (DDA) assists individuals with developmental disabilities and their families to obtain services and supports based on individual preference and capabilities and needs. DDA services help promote everyday activities, routines and relationships common to most citizens.

- Roads to Community Living is a demonstration project designed to help people with complex, long-term care needs move back into the community.

- Community Residential Services include both Alternative Living Services and Companion Home Services, which are provided in typical homes or apartments in the community.

- Home and Community Services (HCS) promotes, plans, develops and provides long-term care services for persons with disabilities and the elderly who may need state funds (Medicaid) to help pay for them.

State Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application – Required for MHBG

*Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in **42 U.S.C. §300x-3** for adults with SMI and children with SED. To assist with implementing and improving the Planning Council, states should consult the **State Behavioral Health Planning Councils: An Introductory Manual.***

Planning Councils are required by statute to review state plans and annual 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 advocates for individuals with M/SUD. States should include any recommendations for modifications to the application or comments to the annual report that were received from the Planning Council as part of their application, regardless of whether the state has accepted the recommendations. States should also submit documentation, preferably a letter signed by the Chair of the Planning Council, stating that the Planning Council reviewed the application and annual report. States should transmit these documents as application attachments.

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

1. ***How was the Council involved in the development and review of the state plan and report? Attach supporting documentation (e.g., meeting minutes, letters of support, etc.)***

The Behavioral Health Advisory Council (BHAC) was involved in the development and review of the state plan and report throughout the past year. To ensure ample time for thoughtful review and input, a copy of the FY2024-25 Block Grant application and priorities was submitted to BHAC for review in early December 2024. The Block Grant Administrator then presented at the January 2025 meeting, reviewing in detail the Block Grant priorities and most recently reported outcomes submitted in the December 1st Block Grant Progress Report. The council formed workgroups to go over each priority before drafting final recommendations on the priorities they presented to DBHR leadership at the Advisory Council March 2025 meeting.

The Block Grant team, along with input from DBHR leadership, reviewed the feedback provided by BHAC and provided a written response to the recommendations submitted to DBHR.

At the July 2025 BHAC meeting, the Block Grant Administrator presented the newly written draft priorities for the FY2026-27 Block Grant application, which took into account recommendations provided by the council on the prior application's priorities.

2. What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment, and recovery services?

Washington States planning council is integrated to address both mental health and substance use prevention, SUD treatment, and recovery services. The Behavioral Health Advisory Council sets aside multiple times on their yearly calendar to review and send recommendations to DBHR on the Block Grant application and its priorities. The Block Grant Administrator provides a Block Grant summary report at every planning council meeting, providing an overview of the block grant timeline, and budgeted and obligated funding broken down by investment area for each award. A Federal Block Grant Progress Report is presented at the January meeting. The

Council then meets to identify needs and gaps in service and then sends written recommendations on the Federal Block Grant to DBHR at their March meeting. The Block Grant Administrator also presents a draft of the state's Block Grant priorities at the July meeting for the Council to review and comment on before the final application is submitted to SAMHSA.

Recommendations from the council, along with recommendations received by the tribes during tribal listening sessions, Roundtables and Tribal Councils, and recommendations received during the public comment period are taken into consideration for identifying needs and gaps in service for substance misuse prevention, treatment and recovery services.

3. Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work?

Yes

4. Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?

Yes

5. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

The Behavioral Health Advisory Council (BHAC) was formed in 2012 and meets six times per year. Its membership is comprised of consumers and community members, including individuals with lived experience, family members or parents of children with SMI or SED, and Peer supports that represent the geographic and social diversity of the state with continued thoughtful recruitment efforts remaining under way to ensure representatives of tribal governments and other communities have council seats reflective of the population served.

In January 2024 the council's lived experience ratio dropped to thirty-three precent due to several members reaching their term limits. Through extensive recruitment efforts the Planning Council's Membership subcommittee, supported by the council coordinator, recruited fourteen new members by August 2024, increasing the council's lived experience ratio to 61% as well as recruiting tribal and youth representation for the first time in two years. A second round of recruitment occurred April 2025 bringing the lived experience ratio to 62% as of June 2025.

The council also includes many partners and stakeholders from other state agencies including the Health Care Authority, Department of Corrections, Developmental Disabilities, Juvenile Rehabilitation, Department of Commerce-Housing, Department of Social and Health Services, the Office of the Superintendent of Public Instruction, as well as from regional Behavioral Health Organizations, Tribes, and providers. The Division of Behavioral Health and Recovery has utilized the collected group experience of the council to identify issues affecting service delivery and the impact of integration.

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

See next page for BHAC forms.

Behavioral Health Advisory Council Composition by Member Type

Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2026 End Year: 2027

Type of Membership	Number	Percentage of Total Membership
1. Individuals in recovery (including adults with SMI who are receiving or have received mental health services)	10	
2. Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)	2	
3. Parents of children with SED	3	
4. Vacancies (individuals and family members)		
5. Total individuals in recovery, family members, and parents of children with SED	**15**	**51.72%**
6. State Employees	9	
7. Providers	1	
8. Vacancies (state employees and providers)		
9. Total State Employees & Providers	**10**	**34.48%**
10. Persons in Recovery from or providing treatment for or advocating for SUD services	3	
11. Representatives from Federally Recognized Tribes	0	
12. Youth/adolescent representative (or member from an organization serving young people)	1	
13. Advocates/representatives who are not state employees or providers	0	
14. Other vacancies (who are not individuals in recovery/family members or state employees/providers)		
15. Total non-required but encouraged members	**4**	**13.79%**
16. Total membership (all members of the council)	**29**	

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes: