Abstract

Cooperative Agreement for State Youth Treatment Implementation

The Washington State Department of Social and Health Services (DSHS), Behavioral Health Administration (BHA), Division of Behavioral Health and Recovery (DBHR), Washington State Youth Treatment Improvement (WSYT-I) project is designed to enhance treatment and recovery services for youth (ages 12 to 18) who have a substance use disorder (SUD) diagnosis and youth who have a co-occurring substance use disorder and mental health disorder diagnosis (COD).

The WSYT-I project will improve access, quality, coordination, and continuum of care through the use of an evidence-based standardized assessment tool; implementation of family centered/informed EBP; increase of care coordination and recovery support services; and inclusion of youth and family/caregiver participation at all levels. An additional focus of the project will be to enhance workforce training and development for the delivery of youth SUD and COD services.

The target population is youth ages 12-18 who are locally identified, with priority going to youth with COD and/or youth involved in multiple systems, such as child welfare and juvenile justice. Our attention will focus on the behavioral health disparities impacting racial and ethnic groups, and lesbian, gay, bisexual, transgender and questioning (LGBTQ) individuals. Services will be delivered by five community-based treatment providers in five geographic areas. Over the three years of the project, we will serve 570 youth and their families/caregivers.

In collaboration with these five community-based treatment providers, the youth and families/caregivers they serve, and child serving system partners, this project will develop and promote recovery oriented service systems. It will provide an interactive and collaborative learning experience that identifies barriers and tests solutions, while implementing family-centered intervention. The framework of the model will be disseminated throughout the state.

Workforce development efforts will focus on an accelerated online certificate for advanced professionals to become state certified substance use disorder professionals. Additionally, a multi-year training implementation plan will enhance the statewide youth/family/caregiver service delivery systems across the state.

The overall objective of the project is to improve health outcomes for youth and improve the youth treatment workforce. Success will be measured via increased rates of abstinence; enrollment in education, vocational training, and/or employment; social connectedness; decreased juvenile justice involvement; and an increase in the number of professionals trained to provide SUD and COD services.

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SECTION A: POPULATION OF FOCUS AND STATEMENT OF NEEDS

A. 1. Population of Focus

The population of focus for this project is youth (ages 12 to 18) with a substance use disorder (SUD) diagnosis or co-occurring substance use and mental health disorder diagnosis (COD) and their families/caregivers. The priority populations will be: 1) youth with COD; 2) youth involved in multiple child serving systems such as child welfare and juvenile justice; and 3) youth who are impacted by behavioral health disparities.

DBHR uses the Treatment and Assessment Report Generation Tool (TARGET), a web-based management and reporting system to generate substance use disorder treatment data. Approximately 525 treatment agencies, including 96 youth-serving, throughout Washington State report data on client services they provide into the TARGET system.

TARGET data from CY2010-2013 indicated that there were 18,355 unduplicated youth admitted into publicly funded SUD treatment. Almost twenty-five percent of these youth received treatment for a mental health issue during the month of admission to SUD treatment or during the year following initiation of SUD treatment as determined by service records in DBHR's Mental Health Consumer Information System. From this data, baseline MH service use among youth receiving publicly funded substance abuse treatment between CY2010-2013 was established:

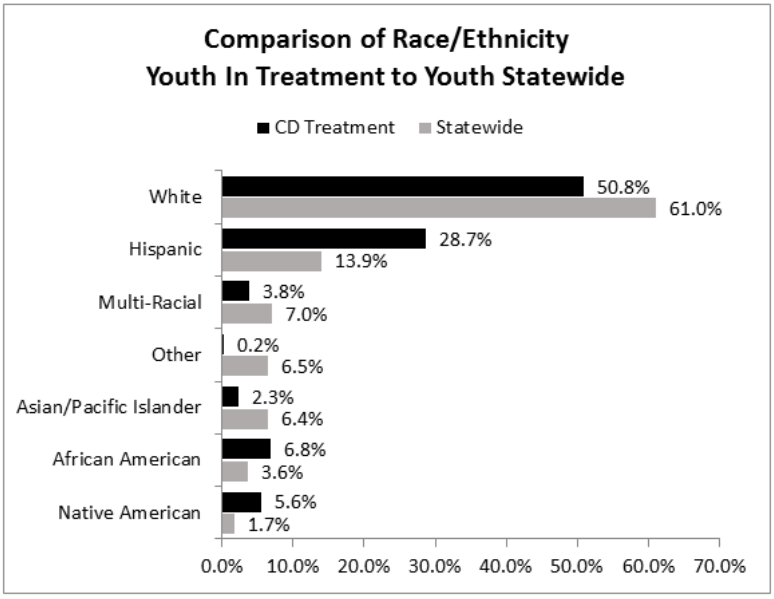
- 13.0% received treatment for a mental health issue during the month of their first admission to SUD treatment between CY2010-2013.
- 25.6% received treatment for a mental health issue during the month of their first admission to SUD treatment between CY2010-2013 or at some point in the prior year.

The demographics of youth recipients of publicly funded substance abuse treatment during CY2010-2013 are as follows:

- ***Gender****:* Female 33.2%; Male 66.8%
- ***Ages***: 12 years 1.4%; 13 years 6.3%; 14 years 13.8%; 15 years 21.6%; 16 years 23.4%; 17 years 22.4%; 18 years 11.2%
- ***Race***: White 50.8%; Hispanic 28.7%; Other 1.7%; Multi-racial 3.8%; African American 6.8%; Native American 5.6%; Asian/Pacific Islander 2.3%; Unknown 0.3%
- ***Sexual orientation***: Didn't say 15.4%; Gay, Lesbian, Bisexual, or Transgender 3.6%; Heterosexual 80.0%; Questioning 0.04%
- ***Juvenile Justice***: 53.6% of these youth were in involved with criminal justice system: 30.0% on probation/parole, 8.4% diversion, 7.6% awaiting charges, 3.2% awaiting trial, 3.4% in supervised program, 3.1% in drug court.
- ***School***: 57.7% were enrolled in school full time, 18.9% were not enrolled, 5.1% were enrolled part time; 18.3% were suspended or expelled.

A. 2. Sub-Population Disparities

To assist our exploration of disparities in treatment for substance use disorders among youth, we compared the count of youth in need of SUD treatment (defined as having at least one substance-related diagnosis, procedure, prescription, or arrest) to those that have actually received treatment. Statewide, among youth in need of treatment 40% received treatment. A sub-group will be considered "underserved" if the proportion receiving treatment is notably below 40%. (Source: DSHS Integrated Databases; Washington State Administrative Data).



With this information we know that population of focus for this project is more diverse than the statewide population as a whole. With the exception of Asian/Pacific Islanders and multi-racial individuals, non-white youth are over-represented in treatment and white youth are under-represented in comparison to the general population. (Sources: TARGET data available through 12/2013; Office of Financial Management (OFM) population estimates by age/race 2010).

Using the backdrop, the following statewide disparities in service provision were noted within the population of focus and will be addressed in the implementation of the project:

- **Gender**: From 2010 through 2013, youth entering treatment were 66.8% male and 33.2% female.
- **Sexual identity – sexual orientation and gender identity**: 4% identified themselves as Gay, Lesbian, Bisexual, Transgender, or Questioning.
- **Disability:** 5% identified as having a physical disability.

Additional considerations include language and socio-economic status:

- **Socio-economic status:** All DBHR youth receiving publicly-funded substance use disorder treatment qualify based on family income at or below 220% federal poverty level.
- **Language and literacy:** DBHR will address issues pertaining to language and literacy by using DBHR-funded interpreter services to address any language barriers (spoken, and deaf and hard of hearing) encountered while providing services to individuals and their families who are in treatment.

Under Washington's current State Adolescent Treatment Enhancement and Dissemination (SAT-ED) project, we are also conducting some more in-depth analyses on disparities relating to: (1) Estimated rates of alcohol and drug use; (2) Estimated rates of need for substance use disorder treatment services; and (3) Youth substance abuse treatment penetration. This complex set of analyses pulls together information from multiple data sources: survey data from the Healthy Youth Survey (HYS), a survey of public school students across Washington State; survey data from the National Survey of Drug Use and Health (NSDUH); population estimates from the Washington Office of Financial Management Forecasting Division; and administrative data from RDA integrated client data base. Results from this set of analyses will inform work under the WSYT-I project. Preliminary results from the Healthy Youth Survey data from 2012 show that 10th grade public school students from different demographic groups report different rates of alcohol and drug use. For example, youth with lower socioeconomic status (as indicated by lower self-reported parental education) and youth from racial and ethnic minority backgrounds, on average, report higher rates of substance use relative to their peers. The ongoing set of analyses will examine the different rates of need for substance use disorder treatment services across demographic groups, and whether treatment services are allocated in parallel to needs.

A. 3. Nature of Problem

The Division of Behavioral Health and Recovery (DBHR) is the single state agency responsible for overseeing publicly funded prevention, intervention, treatment, and recovery supports for substance use disorder and mental health services for Washington State youth and adults. DBHR also certifies community-based outpatient and residential treatment service providers. We contract with counties that oversee substance use disorder outpatient services. Additionally, we have direct contracts with residential substance use disorder agencies.

DBHR has an obligation to oversee the provision of services that demonstrate effectiveness and are deemed appropriate for youth and their families/caregivers. However, several service gaps were identified in the state's strategic plan, "Improving the Statewide Adolescent Treatment System of Care[i]," including:

- Continuity of care between residential and outpatient lacks coordination.
- Cross-system coordination between school, juvenile justice, mental health, and other youth serving agencies needs to be stronger.
- Recovery support services are not well developed across the state.
- Family involvement in treatment, especially outpatient, is minimal.
- The knowledge and skills of the workforce need targeted development.
- Funding and reimbursement rates are not sufficient to cover the full costs of delivering care

Geographic Areas to be Served

Washington State has 39 counties and 29 federally recognized Indian Tribes. We have three identified service regions in the state comprised of diverse and unique small, medium, and large counties that also include both rural and urban communities. The Cascade Mountains run north and south in the state, creating a natural east and west division of the state. Approximately 60

percent of Washington's residents live in the Seattle metropolitan area in King County in the western area, which has a total population of 1,931,249 (2010). For this project we are interested in working with providers from both eastern and western Washington. The following provider sites have been selected in western Washington: 1) True North Student Assistance and Treatment Services (Grays Harbor County), 2) True Star Behavioral Health Services (Clallam County), 3) Consejo Counseling and Referrals Service (King County), and 4) Center for Human Services (King County). The specific site in eastern Washington has not yet been identified. DBHR will conduct a full procurement and issue a Request for Proposal (RFP) immediately after award of grant funds.

A. 4. Current Infrastructure, Statement of Need, and Baseline Criteria

DBHR's strategic goals include effective integration of services for youth with COD and their families/caregivers and to better serve those involved in multiple youth serving systems (i.e., child welfare and juvenile justice).

To accomplish these goals, DBHR must address several infrastructure shortcomings, including:

- Services for SUD treatment have historically been applied in an acute care model which research has shown does not meet chronic care needs.
- Standards of care for COD services do not exist in the state.
- Lack of youth and family/caregiver involvement at state and local levels to inform policy, program, and effective practice.
- Cost of implementation and fidelity for Evidence Based Practices (EBP) is a burden on service providers. Therefore, selection of EBP is often driven by cost instead of the needs of the intended population.
- Recovery support services are not covered for youth and their families/caregivers under current state funding structure.

Acute Care Model vs. Chronic Care Model

National research has demonstrated that applying an acute care model of clinical intervention alone is not sufficient to sustain long-term recovery for youth with COD. For example, first-year, post-treatment relapse rates (measured as at least one episode of substance use) for youth range from 60 to 70 percent (Godley et al., 2002[ii]; White, 2008[iii]). The needs of our youth will not be met with one treatment episode of care.

Addiction is recognized as a chronic disease. However, most treatment for addiction uses acute care interventions rather than a disease management approach. For many people seeking recovery, this approach creates a revolving door of multiple acute treatment episodes. Under the leadership of the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT), the substance use disorders treatment field is shifting from an acute care model of treatment to a chronic care approach, known as recovery-oriented systems of care (ROSC) (Kaplan, L; 2008[iv]).

The state intends to shift to a chronic care approach, with ROSC being the identified model. ROSC models will need to incorporate linguistic and cultural competence to address issues

reaching across health disparities within sub-populations of the youth and families/caregivers receiving services.

COD Services
Standards of care need to be established for youth presenting with SUD diagnosis and COD. Baseline data for COD youth was identified in Section A.1., Sub-Population Disparities.

Youth and Family/Caregivers Voice and Choice
Washington State has a history of collaboration and partnership with youth treatment providers but lacks a service delivery system that uniformly involves families and youth at the state and local levels to inform policy, program, and effective practice. The SAT-ED project focused part of its work to develop this infrastructure by establishing four regional ROSC workgroups. However, the state needs to further develop the infrastructure to ensure a more robust system for youth and family feedback. Continual work is needed to develop the infrastructure to allow timely feedback and on-going opportunities for collaboration. This work will ensure that the needs of youth and their family/caregivers are embedded at all levels of policy, service planning, and implementation of on-going treatment and support.

Enhanced Services
Federal, state, and local funding mechanisms need to be identified and coordinated to best support the implementation of family centered EBPs and to support recovery support services.

Baseline Criteria for System Change
Implementation of this will project addresses all elements of the system limitations identified in the state's strategic plan for youth substance use disorder treatment.

Recovery Support Services
Through our existing SAT-ED grant, we collected feedback from youth on what they want/need for recovery support services, as well as specific services received. A questionnaire on recovery support services was completed by 39 males, 9 females, and 3 who identified as both genders, with ages ranging from 13 to 18 years old. A sample question and answer from the survey follows:

- *Question*: What types of recovery support services would you like or need?
- *Youth Responses*: "Sports; hobbies for all kids and even adults/sober supportive friends;" "I would like support and kindness as a type of service;" "meeting ran by youth for youth;" "friends support and more family counseling/more family support;" "more counseling and other activities;" "fun activities;" "a job to keep me busy and learn to be responsible."

The most common recovery support services received to date by SAT-ED participants include drug-free activities and support (62%), basic needs support (42%), transportation (38%), and educational service support (14%) (SAT-ED Enrollment and Evaluation Update, April 2, 2015).

The selected community-based providers will establish separate baselines for individual youth and families, based on their assessed specific, and provide tailored recovery support services in their own communities to address these needs.

Infrastructure Change

The baseline for infrastructure change is identified in the state's strategic plan, "Improving the Statewide Adolescent Treatment System of Care." From this plan, we have collected feedback from youth, families, and system partners on the needs for enhancing treatment and recovery supports. In 2008, a strategic plan for Washington State was developed as a part of SAMHSA's State Adolescent Substance Abuse Treatment Coordination Grant (TI-17366) grant. This strategic plan includes synthesized data from youth-related research from 1997 to 2005 and feedback from a series of statewide focus groups. The participants included cross-system partners, youth, and families, and providers. The focus groups assessed the strengths and limitations of the youth treatment system. The strategic plan identified these seven areas focused on enhancing youth treatment, representing the baseline for systemic change: 1) establishing a statewide youth treatment council; 2) recruiting and preparing a qualified entry-level youth treatment workforce; 3) continued development of a sustainable and qualified workforce; 4) developing core elements of an integrated recovery-oriented system of care; 5) treatment guidelines and protocols; 6) recovery management and support; and 7) funding and reimbursement strategies.

During the past several years, state initiatives related to the Washington State System of Care (SOC) and SAT-ED grants have successfully developed a statewide youth treatment council (Statewide Family, Youth, and System Partners Round Table [FYSPRT]), and is making significant progress toward preparing a qualified and sustainable youth treatment workforce. Efforts have been made at the individual agency level, through a few county based network systems, in addition to being addressed in state level workgroups. The WSYT-I project offers the funding opportunity to implement a state-led initiative to assist with facilitating change, achieving the seven core elements of the state's strategic goals, and providing enhanced data that will help to further develop the overall strategic plan.

SECTION B: EVIDENCE BASED SERVICES

B. 1. Purpose of Project

The project is designed to improve the existing treatment and recovery infrastructure for youth (ages 12 to 18) with SUD and COD and their families/caregivers. The priority populations served at the five community-based provider sites will be: youth with COD, youth involved in multiple child serving systems such as child welfare and juvenile justice, and youth who are impacted by behavioral health disparities.

B. 2. Evidence Based Assessment and Practice

Responses to a Request for Information (RFI) issued by DBHR in 2012 uncovered a significant interest among community based providers to implement GAIN and A-CRA as a standard approach for serving youth with SUD and COD. Working closely with SAMHSA, DBHR subsequently elected to use both the GAIN assessment tool and A-CRA for its work under the SAT-ED project. Moving forward with the Washington State Youth Treatment Implementation (WSYT-I) grant, DBHR will continue to implement GAIN and A-CRA across an expanded

network of provider organizations with goals and objectives designed to enhance our statewide capacity to deliver high quality services.

The GAIN is a standardized bio-psychosocial assessment that integrates clinical and research measures into one comprehensive structured interview with eight main sections: background, substance use, physical health, risk behaviors, mental health, environment risk, legal involvement and vocational correlates. The GAIN's main scales have demonstrated excellent to good internal consistency (alpha over .90 on main scales, .70 on subscales), test-retest reliability (Rho over .70 on problem counts, Kappa over .60 on categorical measures) and GAIN measures have been validated with time line follow-back methods, urine tests, collateral reports, treatment records, blind psychiatric diagnosis, Rasch measurement models, confirmatory factor analysis, structural equation models, and via construct or predictive validation

A-CRA is an adaptation of the Community Reinforcement Approach, which was initially developed and tested with adults (e.g., Azrin et al., 1982v; Hunt & Azrin, 1973[vi]; Smith et al., 1998[vii]). A-CRA is a behavioral therapy that seeks to use social, recreational, familial, school, or vocational reinforcers and skill training so that non-substance using behaviors are rewarded and replace substance use behavior (Meyers & Smith, 1995[viii]). A-CRA uses a positive, non-confrontational approach, while emphasizing engagement in positive social activity, positive peer relationships, and improved family relationships. Four sessions are specifically designed for parent/caregivers.

The EBP shows evidence that the practices are effective for the populations of focus. Analysis of data from over 2,000 youth across 33 sites revealed that A-CRA was well-implemented across gender and racial groups and had equally effective substance use outcomes across racial groups and treatment gains were also equivalent for males and females (Godley, Hedges, & Hunter, 2011[ix]). Particularly important to the project, a recent path analysis of 1,467 youth who reported past year illegal activity at substance use treatment intake provided evidence that reductions in illegal activity and juvenile justice involvement were achieved through A-CRA treatment; and the relationship between treatment and these reductions were mediated by reductions in substance use (Hunter et al., 2012 under review[x]).

With regard to COD, there is evidence from a study by Slesnick et al., (2007[xi]) that A-CRA participants improve significantly on depression measures relative to control. Additional evidence suggests that A-CRA is effective for reducing symptoms of co-occurring trauma, emotional (e.g., depression, anxiety, suicide), and behavioral (e.g., Attention Deficit Hyperactivity Disorder (ADHD), and SUD) mental health disorders when its outcomes are compared with other evidence-based substance use treatments for youth. Additionally, A-CRA has been identified as a research-based program in the State of Washington under the University of Washington Evidence Based Practice Institute.

B. 3. Addressing Sub-population Disparities

At the local level, information will be reviewed to identify any sub-population disparities in outcome data resulting from the selected EBP. An initial review will set the scope for reviewing and addressing any identified disparities at the local level. Youth and family representatives will

participate in the process to identify responsive strategies to address disparities (i.e., racial, ethnic, sexual orientation). During the course of the project, both qualitative and quantitative treatment outcomes data will be collected and analyzed to identify any disparities. If data shared during the feedback communication loop between youth, family/caregivers, community, and the provider site, indicates sub-population disparities, a "plan to action" to follow-up and address these concerns will be required. If sub-population disparities arise in access, use, or outcomes, interventions will be reviewed at the all levels of the system. This project review process will be on-going to ensure a responsive and culturally competent approach.

Gender and Sexual Identity

DBHR in consensus with project participants will select an intervention that is representative of youth who were admitted into treatment at their site. DBHR will address issues pertaining to sexual identification by encouraging the local community-based providers hire staff members who reflect the populations that are admitted into their treatment program. DBHR is committed to providing additional culturally competent training and/or technical assistance on an as-needed basis.

Disability

The Americans with Disabilities Act of 1990 (ADA), is a requirement of all DBHR/Provider contracts. Additionally, we will consult with the DBHR ADA specialist or certification staff, if disability issues are brought to DBHR's attention as barriers to treatment at any of the selected local community-based providers. DBHR will encourage the local community- based providers to hire staff members who are sensitive and responsive to the disabilities of the youth and families who are receiving services in their treatment facility. DBHR is committed to providing additional training and/or technical assistance on an as-needed basis.

Language and literacy

In accordance with Standard 5 of the National Standards for Culturally and Linguistic Appropriate Services, DBHR will address issues pertaining to language and literacy by using DBHR-funded interpreter services to address any language barriers (spoken, and deaf and hard of hearing) encountered while providing services to individuals and their families who are in treatment. DBHR will seek the consultation of the DSHS' Limited English Proficiency Advisory Committee as needed. In addition, DBHR will encourage the local community-based providers to hire staff who fluently speak the language/languages of the populations who access their treatment services.

At the state level, this project, SOC partners, and FYSPRTs, are informed by the DSHS Cultural Competence Initiative under the auspices of the Office of Diversity and Inclusion. Information will be disseminated to inform policy, workforce training, and enhance cross system initiatives.

- The Health Disparities Work Group formed in 2010 developed policy priorities and system level recommendations related to health disparities across race, ethnicity, religion, gender, age, geography, socioeconomic status, language, sexual identity, and intellectual and physical disabilities.

- The DSHS Cultural Competency Policy and Guidelines became effective in 2011 and provides a framework for all DSHS administrations and employees for cultural competency and delivering culturally responsive services. The guidelines have performance requirements for each administration (i.e., Behavioral Health Administration's Cultural Competence Action Plan).

B. 4. Modifications of Evidence Based Practices

DBHR will identify the need for any modifications or adaptations to practices by reviewing Government Performance and Results Act (GPRA) performance measures, TARGET data, and local community-based provider feedback every six months. We will justify any modifications or adaptations to practices by reviewing the GPRA performance data that has been reported to SAMHSA. Additionally, feedback from the youth and their families/caregivers receiving services and from the treatment providers will be used to justify modifications or adaptations, particularly adaptations to address any needed cultural competencies, as addressed by the Health Disparities Work Group.

Proposed adaptations will be reviewed by DBHR to ensure that they are consistent with improving the likelihood of success in meeting the goals and objectives of this project.

We will consult with the EBP developer to determine any possible impact to outcomes from the proposed adaptations to modify the training and implementation plans and data collection.

In addition, we will seek pre-approval from SAMHSA staff before moving forward with an adaptation to the selected EBP.

SECTION C: IMPLEMENTATION APPROACH

State Adolescent Treatment/Youth Coordinator

Diana Cockrell, CDP, is the Behavioral Health Youth Treatment Coordinator at DBHR. She has over 10 years of experience working with youth and families as a therapist, supervisor and program manager. Diana holds a Chemical Dependency Professional state certification and has experience working with youth with substance use disorders and families referred to treatment through schools, court, and family concern. She is currently is responsible for the planning and coordination of all state SUD youth residential contracts, monitoring, utilization and movement of funds. She also works on statewide policies and programs such as Youth Systems Improvement, Chemical Dependency Disposition Alternative with the Juvenile Justice and Rehabilitation Administration, and expanding youth evidence based treatment and residential bed capacity in the youth serving system

WSYT-I funds are currently utilized to employ the existing WSYT-I 1.0 FTE Project Director, Pedro Garcia. His role is to support the Treatment Coordinator with items such as; contract management, site visits, and Government Performance and Results Act (GPRA) data. The Authorized Representative will oversee this project, participating in meetings and other activities as necessary.

Interagency Council

Under the current SOC and SAT-ED project, cross system partners have come together to address the needs of children's behavioral health services in the state by forming a Statewide Family Youth System Partner Round Table (FYSPRT). This project will use the already established cross systems work groups to further enhance collaboration among the current child serving systems. Representation for this cross system work has partnership with Children's Mental Health, Child Welfare, Juvenile Justice, Division of Developmental Disabilities, Department of Health, Office of Superintendent of Public Instruction, Health Care Authority (the state Medicaid Agency), the Behavioral Health Advisory Council, tribal representation, and youth/family representation from the established Regional FYSPRTs. Leadership of the Statewide FYSPRT includes tri chairs that include: one family, one youth, and one system partner. This further aligns with the goal of incorporating youth and family voice into our children's behavioral health system.

The Statewide FYSPRT will meet every quarter or as needed to track issues and the progress of the project's implementation and provide on-going statewide support to its stakeholders. Meetings are attended by a member of the Executive Leadership Team and Statewide FYSPRT members including state partners (JJRA, DDA, CA, OSPI, DOH and HCA), Regional FYSPRT Tri-Leads, a SAT-ED representative, tribal representative(s) and DBHR. Two work groups established to report to the Statewide FYSPRT include the Children's Behavioral Health Finance Committee and Workforce Development Team.

The Children's Behavioral Health Finance Committee consists of identified fiscal leads from individual administrations (CA, JJRA, DDA, and DBHR), which focus on the goal of developing sustainable financing and aligning funding to ensure services are seamless for children, youth, and families. Additionally, ongoing tasks include bringing together financial maps and plans related to children's behavioral health services and making recommendations on policy and practices.

The Workforce Development Team concentrates on developing and strengthening a workforce that will operationalize core SOC values. Workforce development plans are reviewed and a collaborative workforce plan is created for children's behavioral health.

The goals, values, and principles of the Statewide FYSPRT are monitored to determine the degree of integration into institutional processes and behavioral health service delivery. Statewide FYSPRT responsibilities related to participation in infrastructure reform, policy development, and youth family involvement at the policy and practice level are:

Engaging in quality improvement practices; Ensuring that project scope aligns with the agreed business requirements of key stakeholder groups; providing input into children's behavioral health priorities, direction and approaches; collaborating to accomplish project deliverables; and Providing work group oversight.

Financial Mapping
A financial map was prepared from State Fiscal Year 2013 to examine the existing financial structures supporting youth treatment services. DBHR has two delivery methods for youth SUD services; direct contracts with youth residential providers and contracts with counties who then sub-contract for youth outpatient services. The financial map findings suggest Medicaid supports more services than any other funding source within our entire youth treatment system. Specifically, there are more referrals to non-IMD residential treatment services than state funded programs, which accounts for 44.8% of the total funds expended for youth services. Additionally, our cross-system partners refer Medicaid eligible youth into DBHR's publicly funded treatment system for services.

Workforce Mapping
A workforce map was developed under the SAT-ED project, which gathered information from our Behavioral Health Treatment Provider Survey. This survey is sent out to all publicly funded SUD treatment facilities in our state. With this survey, we are able to capture the characteristics of the current workforce for SUD and COD youth treatment services such as level of education and training in EBP. This same activity will be replicated for WSYT-I, as it provided essential data to determine the needs of the workforce.

Lessons learned from the SAT-ED project prompted selection of the following activities for recruitment, preparedness, and retention of a qualified workforce to serve our population of focus:

Prepare faculty in appropriate college and education settings to deliver curricula that focus on youth specific SUD EBP.
In our SAT-ED project, two colleges successfully provided GAIN courses to offer credits toward degree, certification, and access to the Assessment Building System (ABS) web accounts to students.

We plan to offer a GAIN college course in order to help prepare students entering the workforce trained in the required evidence based assessment.

As part of the GAIN service package for college students, Chestnut will provide:

1. GAIN ABS web accounts for up to 45 active users to support conducting the assessment, generating and editing the bio psychosocial narrative report summarizing diagnosis and placement, other interpretative reports if required, and the ability to export the data for analysis (or local IT system depending on what it is and/or someone doing the work to link them outside of this subcontract);
2. Online GAIN College Course access and certification costs for up to 31 students;
3. Technical support as requested, including monitoring, coaching, and the cost of calls and teleconferences to implement and use the data to support both individual level clinical decision making and program level evaluation and program development;
4. This package includes accessing pooled data from other grantees to support monitoring, evaluation and program planning, and adding site data to the pooled data.

Employ technology to expand the delivery of training opportunities to workforce especially in rural areas.

The Spokane Falls Community College (SFCC) Addiction Studies Program is proposing to develop and offer an accelerated 15 credit, Online Certificate to meet the new requirements for advanced professionals to become Certified Chemical Dependency Counselors in Washington State.

SFCC will partner with Spokane School District and Daybreak Youth Services to offer this educational certificate to 30 employees who are currently mental health counselors. These advanced professionals provide mental health services to the 30,000 students within the Spokane School District and to youth attending treatment at Daybreak from around the state. The goal of this partnership is to provide the incumbent workforce with necessary education to become dually certified as COD professionals to provide broad and accessible services.

The Department of Health is in its final phase of developing the new Washington Administrative Code (WAC 246-811-077) which outlines the new alternative educational requirements for advanced professionals to apply for Chemical Dependency Professional Certification (CDP). The advanced professionals include the following:

- Advanced registered nurse practitioners under chapter18.79 RCW;
- Marriage and family therapist, mental health counselor, advanced social worker, or independent clinical social health worker under chapter18.225 RCW;
- Psychologists under chapter18.83 RCW;
- Osteopathic physicians under chapter18.57 RCW;
- Osteopathic physician assistants under chapter18.57A RCW;
- Physicians under chapter18.71 RCW; and
- Physician assistants under chapter18.71A RCW.

According to WAC 246-811-076 advanced professionals must successfully complete fifteen quarter or ten semester college credits in courses from an approved school which include coursework in each of the following topics specific to alcohol and drug addicted individuals:

- Survey of addiction;
- Treatment of addiction;
- Pharmacology:
- Physiology of addiction;
- American Society of Addiction Management (ASAM) criteria;
- Individual group, including family addiction counseling; and
- SUD law and ethics.

SFCC's Addiction Studies certificate will consist of three online courses. Each course will be five credits and contain the following topics:

Course 1: Survey of Addiction, Substance Use Disorder Law and Ethics and Intro to Treatment of Addictions (5 credits)

Course 2: Pharmacology and Physiology of Addictions (5 credits)

Course 3: American Society of Addiction Management (ASAM) criteria, Individual, Group, including family addiction counseling (5 credits).

Additional Considerations

State Required Exam: A consideration for this proposal will be to waive the required Washington State exam fee for individuals pursuing a career serving youth, with priority going to professionals serving youth in WSYT-I sites. Washington accepts the National Association of Alcoholism and Drug Abuse Counselor level-one exam as one of two approved test options. This test is usually completed after the completion of all required education and after the completion of supervised clinical practice hours in the workforce. The State allows for students who attend a NAADAC-approved academic program to sit for the exam prior to completing all of the required supervised practice hours. SFCC Addiction Studies program is NAADAC approved and recommends that all students test immediately after completion of the program. SFCC is currently in conversation with NAADAC to ensure that the new 15 credit Certificate will also be approved for early testing. If so, a fee for the test and the facilitation of testing application will be a function of this project. This is not to be confused with assurance that a student passes the exam.

Approved Clinical Supervision: There is a critical workforce shortage of approved SUD treatment supervisors to oversee the clinical practice of these trainees. To address this need, a partnership has been established with SFCC, Spokane Public Schools, and Daybreak Youth Services to implement a pilot project for the clinical supervision of these trainees to ensure they have the hours and support required for certification as Chemical Dependency Professionals.

Another strategy to recruit, prepare, and retain a qualified workforce to serve youth, is to implement webinar and in-person based Learning Collaboratives (LCs) with providers. The LCs will assist with dissemination of the WSYT-I goals and information about Recovery Oriented Systems of Care (ROSC) to site leads and community partners. Additionally, through a shared experience between the state and the local community-based treatment provider sites, an EBP will be implemented, youth and families will be provided services, and a feedback loop will be developed. This process will enable the state and the sites to identify barriers and test solutions in real time.

Throughout the duration of the project, LCs will be implemented within Peninsula, King, Timberlands, and Spokane Behavioral Health Organizations (BHOs). With the current SAT-ED sites, LCs are focused solely on the site's governing county. With this expanded approach of reaching the entire BHO Regional Service Area, several counties will have the opportunity to engage in the LC process. BHOs will also be required to send representatives to an annual statewide in-person Learning Collaborative in central Washington. In addition, a statewide in-person LC will be held annually with participating WSYT-I treatment providers. This will create a natural platform for a sustainability plan to project activities.

DBHR will also present on WSYT-I implementation and activities at the annual statewide Co-Occurring Disorder Conference. This conference is attended by over 600 behavioral health professionals, providers, families, and consumers.

Workforce Training Implementation Plan

The evidence based assessment selected is the Global Appraisal of Individual Needs (GAIN). The four primary sites each have confirmed their governing county agrees to use their current funding streams to support implementation of the assessment through contracts with Chestnut Health Services.

The evidence-based treatment model selected is A-CRA. The original two SAT-ED sites are trained, certified, and implementing A-CRA, however; the two sites in King County will need training and certification. This will include communication with Chestnut Health Systems that WSYT-I clinicians are participating and completing certification requirements. As part of our sustainability plan, King County has offered to match A-CRA training and certification and will contract directly with Chestnut Health Services for a full training implementation plan.

The 2012-2015 workforce training plan (Attachment 6) does not include our expansion site, as the plan is to incorporate the site through a Request for Proposal (RFP) process in year two. However, an updated workforce training plan for this expansion site in eastern Washington will include training in the provision of recovery support services. Rolling out services in varying module combinations enhances our ability to evaluate long-term benefits of each service, increasing the probability that the most impactful services will be sustained.

Content and Skill Training

In addition to the GAIN and 15 credit college courses, trainings and events will be conducted in-person, through coaching calls, and webinars. Webinars will be made available to all interested cross-system partners, families, and youth. Trainings will be linked, when possible, with other DBHR workforce development efforts.

Topic areas for trainings include, but not limited to:

- ASAM Criteria training for Mental Health Professionals
- DSM 5
- Co-Occurring Disorder Conference – one youth-focused keynote speaker and five breakout sessions focused on youth
- Community-based SUD treatment: a tutorial for Primary Care Physicians

Three-year Project Plan

As part of our work during the first quarter of grant operations, a work plan was created and will be updated every 12 months. This work plan has program goals, objectives, data/evaluation, activities, time frame (updated with dates and status), and responsible leads. An additional component of this plan includes; Measures of Success: How will the project know it "succeeded" in reaching its goal?

Project Sustainability Plan

As a result of a significant system change, SUD services will be purchased through integrated mental health/SUD contracts beginning in April 2016 through Behavioral Health Organizations (BHOs). As the state moves towards a more regionalized Medicaid purchasing approach, BHOs

will use these funds and different payment strategies to support EBPs. Adherence to providing EBPs comes from several pieces of Washington State legislation, including:

ESHB 1519: Directs the Department of Social and Health Services (DSHS) and the Health Care Authority (HCA) to establish accountability measures for service coordination organizations, i.e.: Regional Support Networks (RSNs), Medicaid managed care organizations, Area Agencies on Aging (AAAs), and county substance abuse coordinators. Contract performance will be based on the following outcomes:

- Improvements in client health status and wellness
- Increases in client participation in meaningful activities
- Reductions in client involvement with criminal justice systems
- Reductions in avoidable costs in hospitals, emergency rooms, crisis services, and jails and prisons
- Increases in stable housing in the community
- Improvements in client satisfaction with quality of life
- Reductions in population-level health disparities

Additionally, DSHS and HCA will maximize the use of evidence-based, research-based, and promising practices, maximize client participation in treatment decisions, and collaborate with consumer-based support programs.

Initiative 502: Directs DBHR to implement plans for the retail marijuana tax funds dedicated to the implementation and maintenance of cost beneficial evidence-based, research-based and promising practices and programs aimed at the prevention or reduction of maladaptive substance use, substance-use disorder, substance abuse or substance dependence, among middle and high school aged youth. The total treatment allocation for FY16-17 is $13,557,000. In addition to funding 40.5 additional beds in two COD intensive inpatient agencies, we will:

- Serve an additional 1,000 youth in outpatient treatment with:
  75% Medicaid at 50% Match (750 youth)
  25% Non-Medicaid (250 youth)
- Funds will support 2 FTEs at Juvenile Justice & Rehabilitation Administration for out-stationed SUD professionals to provide outreach, A-CRA services, and referrals
- Funds will draw an additional $2.3 million in Federal Matching funds to support evidence-based treatment services

House Bill ESSB 2536: Legislated that "prevention and intervention services delivered to children and youth in the areas of *mental health, child welfare, and juvenile justice* be primarily evidence- and research-based and provided in a manner that is culturally competent." SUD treatment for youth was not included in the language of the bill. However, the SUD treatment system needs to continue to increase access to EBP; this project will support this effort.

This project incorporates already established state strategic goals and objectives documented in state and federal planning reports. The services and program models piloted through the grant will be sustained by:

- Shifting funding to effective aspects showing outcomes endorsed by the community (this will include consideration of the Unified Block Grant funding allocated for recovery support and youth specific services).
- Sustainability will be achieved through the clear description of procedures to provide an enhanced array of services through Medicaid.
- Federal block grant funds will be used to promote the adoption and provision of EBP.
- Educating current youth treatment staff to recovery focused treatment model and highlighting successes.
- Continued use of federal grant funds to support the expansion and continued collaborative work of the regional FYSPRT. They partially funded the Unified Block Grant through individual contracts with five family/youth groups and organizations.

Additionally, Recovery Support Services has been identified as a promising practice under the University of Washington Evidence Based Practice Institute (through the work under the SAT-ED project).

At the county and provider level, the determination to select these EBPs includes:

- Two existing SAT-ED project sites are already trained in both EBPs and have the financial resources available to continue to support implementation.
- Two King County sites were chosen due to their diverse populations and the county's ability to provide in-kind GAIN and A-CRA training and certification. This allows the state to allocate those funds to support further expansion of providers in year two along with workforce development efforts.
- In year two we are committed to expanding WSYT-I into eastern Washington through a Request for Proposal (RFP) to address unmet needs geographically. We will ensure the provider has a commitment to implementing recovery support services while fulfilling the capacity to collect client-level data and move towards EBP training at the end of the grant period.
- The training model we will offer, in consultation with Chestnut, is an in-state online training with a local trainer identified at the sites. This method allows clinicians to work online anytime and work with a local trainer on the certification process.

Selection of Two Infrastructure Activities

Existing Family and Youth Statewide Structure: Five regional Family, Youth, and System Partner Roundtables (FYSPRTs) have been established to ensure input of youth and their families/caregivers, and an invitation will be extended to the youth and their families/caregivers from each provider site. A variety of tasks exist within each regional FYSPRT including, education and outreach regarding the available treatment and recovery support services available and family and youth peer support. From each of these five FYSPRTs, one family member and one youth serve on the existing Statewide FYSPRT. FYSPRT contracts are overseen by the SOC Program Manager.

State-level SAMHSA-funded CMHI Grantee: The SOC is part of the recently formed Children and Youth Behavioral Health Unit (CYBHU), formerly Children's Mental Health Unit. The name change reflects the greater vision of an integrated mental health and SUD team for

children, youth, and their families. The CYBHU is under the direct supervision of a dually licensed professional, one Office Chief, and a Director and has a full commitment to establishing and maintaining a formal collaborative relationship with WSYT-I. Over the last three years, the SOC has made significant progress on addressing the identified goals, which interlink to the goals of WSYT-I:

1) Infuse SOC values in all child-serving systems.
2) Expand and sustain effective leadership roles for families, youth, and system partners.
3) Establish an appropriate array of services and resources statewide, including providing intensive services in home and community settings.
4) Develop and strengthen a workforce that will operationalize SOC values.
5) Build a strong data management system to inform decision-making and track outcomes.
6) Develop sustainable financing and align funding to ensure services are seamless for children, youth and families.

C. 1. Culturally and Linguistic Appropriate Services

Our project will adhere to the National Standards for Culturally and Linguistic Appropriate Services (CLAS) by first setting the foundation by focusing on meeting the Principal Standard 1: Provide Effective, Equitable, Understandable, and Respectful Quality Care and Services.

Furthermore, we will address Standard 3: Recruit, Promote, and Support a Diverse Governance, Leadership, and Workforce by utilizing several of the strategies for implementation as described in the Workforce Map and Workforce Training Implementation Plan:

- Develop relationships with local schools and training programs to expand recruitment base.
- Collaborate with public school system to build potential workforce capacities and recruit diverse staff.
- Develop, maintain, and promote continuing education and career development opportunities so all staff members may progress within the organization.

Standard 13: Partner with the Community is a commitment of the WSYT-I project. We intend to build upon Learning Collaboratives and FYSPRT involvement to build capacity for policy and program changes to meet the needs of the different cultural backgrounds of each community population.

A focus of the Behavioral Health Disparities impact statement will be on further enhancing our commitment to meeting the National CLAS Standards.

C. 2. Effective and Efficient Service Delivery by Selected Providers

The following state certified SUD providers have been selected to deliver effective and efficient WSYT-I services based upon their ability to meet the expectations of this project. We built upon the two rural sites from the SAT-ED project and expanded the project to include two new urban providers, each with a unique service delivery system. The core components of a WSYT-I site include the measured needs and gaps of the surrounding communities, including disparities, the providers willingness to work with the community, cross-systems partners, family and youth,

their ability to meet GPRA data collection expectations, their ability to implement evidence-based assessments/practices, and their commitment to sustaining the program.

Participation in Learning Collaboratives will be an integral function of each site with a focus on direct treatment, identifying and addressing administrative and population focused service challenges, implementing a quality assurance plan, and collaboration with family and peer support services.

GAIN is a required assessment tool for the following sites. A-CRA and Recovery Support Services will be included in site implementation models based on readiness, need, and resource availability.

Site One: True North Student Assistance and Treatment Services (Grays Harbor County) responds to youth risk factors that exist within the school and community environment. They provide prevention, intervention, treatment, and recovery support in an effort to help students be successful and complete their school experience. They were a SAT-ED site delivering GAIN, A-CRA, and Recovery Support Services.

Site Two: True Star Behavioral Health Services (Clallam County) serves juveniles through 18 years of age. They provide assessments, drug court, detention based treatment, outpatient treatment, DUI assessments, and mental health counseling. They were also selected as a SAT-ED site delivering GAIN, A-CRA, and Recovery Support Services.

Site Three: Center for Human Services (CHS) is located in Shoreline, Washington and has provided services in King County for youth and families since 1970. Although CHS is based in Shoreline, it has satellite offices in Bothell, Mountlake Terrace, and in surrounding school systems. CHS provides youth and adult treatment and assessments, prevention services, services for individuals with co-occurring diagnoses, family support services, and Wraparound and WISe programs.

Site Four: Consejo Counseling & Referral Service (King County) offers culturally-competent behavioral health services to growing yet underserved Latino communities with a focus on families with children. The services specific to youth are: mental health individual and group counseling, Outpatient SUD Treatment, and a gang prevention and intervention program. Of their 75-100 clients, half are identified as Spanish-speaking with clinicians fluent in both English and Spanish.

Outreach and Engagement

School-based presence: In July 2013 RDA published Report 11.194[xii] that described the complex relationships between behavioral health, risk factors associated with social and health service needs, and high school progress and outcomes for DSHS clients who began 9th grade in 2005-06. Among the key findings of that report was that youth with behavioral health needs were less likely to graduate from and more likely to drop out of high school than youth without behavioral health needs. Youth with COD were the least likely to graduate on time (12%) and most likely to drop out (80%). In order to increase access to services, two of the selected sites currently identified offer services within the school setting.

Results Washington: Results Washington is a set of performance measures that reflect Governor Jay Inslee's data-driven continuous improvement system. Retaining chemically dependent individuals in treatment, per their individual treatment plan, is essential to their recovery, and as such is included as one of the state measures. DBHR is committed to working with County Governments to improve retention rates of publicly funded patients in youth outpatient chemically dependency treatment.

Research indicates that remaining in treatment for at least 90 days is associated with positive outcomes, such as reduction in substance use and criminal justice involvement, which aligns with SAMHSA's Strategic Initiative: Trauma and Justice.
Barriers identified to reaching the statewide retention goal of 76.2% are:

- Retention is challenging with limited funding for outreach and case management for the providers to connect with the patients outside of the office.
- Youth are often not participating in treatment without the juvenile justice system, parents, or education system telling them they need to.
- Recovery support services are limited and currently not funded by Medicaid for youth with a primary SUD diagnosis.

A Results Washington workgroup identified "youth system can be difficult to navigate" and "parent/caregiver participation" as activities to focus on to help increase retention rates. The following recommendations were developed:

- Update DBHR Youth Resource and Referral Guides
- Cost effective evidence-based, research-based and promising practices focused on families
- Skill building trainings
- Work with providers on increasing participation in family work (therapy and education)

The main issue with completing the recommendations is a lack of funding to support these efforts. WSYT-I funds, along with our Sustainability Plan, are focused on expanding practices, trainings, and provider technical assistance, thus addressing all four recommendations.

Activities also include:

- Determining the sites need – where to focus energy to strengthen relationships with partners (for example: juvenile justice, schools, mental health agency, etc.)
- Inviting key staff and partners to attend Learning Collaboratives (teachers, superintendents, juvenile detention officers, etc.)
- Designated staff meet with key staff and partners to discuss SUD treatment, prevention, and outreach
- Regional FYSPRTs disseminating information in their communities

C. 3. Screening, Assessment, and Appropriate Treatment Services

This project will train community based outpatient treatment providers on screening and assessment of clients for the presence of COD. The clinicians will use the findings to place the client in the most appropriate Level of Care based on ASAM Criteria. With an emphasis on

clinical practice guidelines and effective case management strategies, the likelihood of effective outcomes increases as clients are supported throughout the treatment process. A developmentally-appropriate behavioral EBP will be used with youth that also seeks family/caregiver involvement. The Recovery Support Services (RSS) Care Coordinator, funded through WSYT-I, will introduce his/herself to the client while still in outpatient treatment to discuss RSS and options for the youth and family/caregiver to continue on a path to recovery and wellness.

Screening and Assessment

The selected sites will implement the Global Appraisal of Individual Needs (GAIN); Dennis et al 2003[xiii]) as our form of evidence-based assessment and A-CRA as the evidence-based treatment model.

The GAIN has been used extensively to support clinical decision making related to diagnosis, placement and treatment planning, to measure change and to document service utilization. The GAIN incorporates American Psychiatric Associations (APA, 2000[xiv]) Diagnostic and Statistical Manual IV text revised (DSM-IV-TR) symptoms for common disorders, the American Society of Addiction Medicine's (ASAM, 2001[xv]) patient placement criteria version 2 revised (PPC-2R) for the treatment of substance-related disorders, and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO, 1995[xvi]) for assessment and treatment planning, as well as questions to map onto several epidemiological and economic studies.

Family centered evidence based practice

A-CRA is an adaptation of the adult CRA model. There are three types of A-CRA sessions: Sessions for youth alone, parents/caregivers alone, and youth and parents/caregivers together. At the beginning of treatment, therapists emphasize that the goal of therapy is to help the youth have a satisfying life without using alcohol and drugs. In A-CRA, there is an emphasis on providing assistance to parents/caregivers and teaching both parents/caregivers and their youth the skills to improve their relationship with each other. At a minimum, the manual suggests two sessions with the parents/caregivers individually, and two sessions that include both the youth and the parents/caregivers together. More of these sessions are possible, if needed, and within the scope of a local treatment provider. A-CRA developers recommend that therapists work with parents/caregivers as soon as possible during the youth's treatment episode to ensure that all four sessions are completed.

Recovery Supports

Youth and families/caregivers will work with a Care Coordinator to identify recovery support services that will assist the youth and families/caregivers recovery, health, and wellness. These services can be flexibly staged and may be provided prior to, during, and after treatment. These services may be provided in conjunction with treatment and as separate and distinct services. Recovery support services include, but are not limited to: vocational training, transportation, mentoring, coaching, self-help and support groups, cultural activities, and spiritual and faith-based support. The number of services received of each type of service will depend on the needs of the individual youth and their families/caregivers.

Behavioral Health Disparities
An impact statement will be submitted no later than 60 days after award. This will focus on a data quality improvement plan for service activities and methods for development of National Standards for CLAS.

C. 4. Roles and Responsibilities of Partnering Organizations

Per Washington State's procurement policies, county government entities will be contracted as proxy organizations for local treatment providers. In this arrangement, the full consideration amount for each county contract will pass-through directly to local treatment providers offering GAIN, A-CRA, and RSS. The identified counties for this project are King County, Grays Harbor County, and Clallam County. In accordance with grant requirements, two providers (Consejo Counseling and Referral Services and Center for Human Services) will provide services in King County; one provider (True North Student Assistance and Treatment Services) in Grays Harbor County; and one provider (True Star Behavioral Health Service) in Clallam County. An additional provider from eastern Washington will implement RSS in year two.

Other organizations that will participate in the project include Chestnut Health Systems, as the entity to provide the evidence-based assessment and practice training and certification authority. The Statewide Family Youth System Partner Round Table (FYSPRT), as the Interagency Council, has representatives from cross-system partners (Attachment 2). Lastly, Spokane Falls Community College, with the support of Spokane Public Schools and Daybreak Youth Services, will partner with DBHR to provide workforce development opportunities.

A formal relationship with SOC is established and DBHR leadership oversees sustainability of this collaboration.

C. 5. Individuals Served

In year one with the four primary sites, we aim to serve 40 youth at each site for a total of 160. In years two and three, with the expansion site, we project to serve 30 additional youth for a total of 190 across all five sites each year. Overall, 570 unduplicated youth will be served over the entire three-year project period. The four primary site enrollment goals correspond with the total number of youth enrolled to date in the SAT-ED project together with local population sizes.

The types of services include: outreach, engagement, assessment, intensive outpatient treatment, outpatient treatment, and recovery support services. Outcomes from these services include increased rates related to accessing services, abstinence, social connectedness, and retention.

As of February 2015, 200 youth had enrolled into our SAT-ED project. The participants were 56% male and ranged in age from 12 through 18 years old. Sixty-four percent of the participants were non-Hispanic white, while 36% of the participants were from one or more minority race or ethnicity categories (20 Hispanic, 20 black, 5 Asian/PI, 33 American Indian/Alaska Native; note that categories are not mutually exclusive). Of those participants who reported their sexual identity, 10% (16 of 166) identified as Gay, Lesbian, Bisexual, Transgendered or Questioning (GLBTQ).

The projections of youth served for the two King County sites are based on county population estimates. Of the 229,867 youth ages 10-19 in King County, 29% are on Medicaid/CHIP. Of these, 2,554 youth age 12-18 have an identified treatment need. Data from the Healthy Youth Survey identified 21% of 10th graders report any alcohol use in the past 30 days and sixteen percent report any marijuana use in the past 30 days. Males represent 51% of the youth population. Fifty-four percent of youth in King County are non-Hispanic (NH) white, 15% are Asian and 13% Hispanic, 8% are black, and 8% are two or more races.

SECTION D: STAFF AND ORGANIZATIONAL EXPERIENCE

D. 1. Organizational Capability and Experience

DBHR has the capability and experience with similar projects and populations. Through our experience with the Access to Recovery and Adult Drug Court Enhancement grants, we have knowledge about providing recovery support services to clients and understand the importance of these services in long-term recovery. DBHR also has successfully implemented the SAMHSA-funded Comprehensive Community Mental Health Services for Children and Their Families Program (CMHI) through the SOC grant, the current focus of which is for youth with Serious Emotional Disturbances. Lastly, DBHR is a recipient of the SAT-ED project intended to disseminate evidence based assessments and practices in two state regions. All of these efforts are inclusive of youth with COD services, and over time will enhance the existing child serving system. The WSYT-I team will align and work with the SOC. The SOC planning efforts have brought together system partners and supports for ensuring youth and family voice. The cornerstone for the existing project is to "expand SOC into the mainstream, and embed it within the system's policies/structures/finances to ensure sustainability." This includes the FYSPRT structure, which uses local family, youth, and community support organizations to inform policies and practices.

DBHR has received commitment from several child-serving agencies to collaborate on this project including, but not limited to: the Juvenile Justice and Rehabilitation Administration (JJRA), Children's Administration (CA), the Department of Health (DOH), the Office of the Superintendent of Public Instruction (OSPI), the Health Care Authority (HCA), and provider agencies. All of the provider agencies have been providing relevant SUD treatment for a minimum of two years prior to the date of the application. The agencies are certified by DBHR, and as such, comply with local and state requirement for licensing.

DBHR has the needed resources to meet the needs of grant implementation. These include sophisticated fiscal controls and oversight, available consultation from the Office of Attorney General, Office of Personnel, Grants Management, and others. Facilities and equipment are available and accessible to grant staff including phones, copy machines, fax machines, work area, and all other equipment needed to operate.

DBHR will ensure quality of care by assuring all treatment providers are certified by DBHR which includes review of safety standards, ADA accessibility, business standards for insurance and licensing, and criminal background checks. DBHR will investigate incidents and complaints

and conduct on-site surveys offering technical assistance to assist providers in meeting state and federal compliance regulations.

D. 2. Key Staff Positions and Level of Effort

State Adolescent Treatment/Youth Coordinator – Diana Cockrell will maintain clinical oversight of provider performance and grant requirements, ensuring that all personnel is properly trained and services are delivered according to fidelity standards (30% LOE in-kind).

Project Director – Pedro Garcia will work with the State Adolescent Treatment/Youth Coordinator and will be responsible for management of the grant's day-to-day operations. The Project Director will oversee implementation of project goals and objectives according to SAMHSA's rules and guidelines (100% LOE).

Evaluation Coordinators – Dr. Barb Lucenko and Dr. Bridget Lavelle will plan and manage all performance evaluation and report statistical analyses (10% LOE).

D. 3. Senior Grantee Agency Staff Involvement

Michael Langer is the Chief of the Office of Behavioral Health and Prevention at DBHR. Reporting to the Division Director, Michael maintains oversight of DBHR's SUD treatment and prevention efforts. Michael will approve appointment of the Project Director, RFP publication, contractor selection, FYSPRT Finance Subcommittee Charter, and attend WSYT-I activities as appropriate.

Chris Imhoff, LICSW, is the Director of DBHR. Chris is the signing authority for DBHR. Chris is responsible for effecting policies and making policy recommendations to the state legislature. Chris will champion WSYT-I goals and communicate milestones to legislators and members of the public as necessary.

D. 4. Key Staff Experience and Qualifications

Diana Cockrell, CDP, is the Behavioral Health Youth Treatment Coordinator at DBHR. She has over 10 years of experience working with youth and families as a therapist, supervisor and program manager. Diana holds a Chemical Dependency Professional state certification and has experience working with youth with substance use disorders and families referred to treatment through schools, court, and family concern. She is currently is responsible for the planning and coordination of all state SUD youth residential contracts, monitoring, utilization and movement of funds. She also works on statewide policies and programs such as Youth Systems Improvement, Chemical Dependency Disposition Alternative with the Juvenile Justice and Rehabilitation Administration, and expanding youth evidence based treatment and residential bed capacity in the youth serving system.

Pedro Garcia, MPA, holds a Master's degree in Public Administration and is a Behavioral Health Program Administrator with DBHR. Pedro has 11 years of professional management experience delivering social services, knowledge of Evidence Based Practices for youth, knowledge of substance use and mental disorders and the correlation between the two, skills to link and coordinate with other child-serving systems, and experience in managing and working

with multiple systems and diverse interests groups. Pedro is also the current SAT-ED Project Director.

Barbara Lucenko, Ph.D. is a clinical psychologist and a research manager in RDA. She specialized in research and program evaluation relevant to behavioral health for complex clients receiving publicly funded services, with a particular focus on children and youth.

Bridget Lavelle, Ph.D. is a demographer and senior research manager at RDA. Her work focuses on quasi-experimental evaluation of a range of physical and behavioral health policy interventions for clients receiving publicly funded services. Her efforts have been integral to the successful data collection and reporting in the SAT-ED project

D. 5. Youth and Family Representation

DBHR will expand the existing infrastructure of the state's current SOC implementation grant. Five regional Family, Youth, and System Partner Roundtables (FYSPRTs) have been established to ensure input of youth and their families/caregivers. The regional FYSPRTs create a statewide forum for family, youth, and system partnership. FYSPRT values related to youth and family representation include: 1) Respect: Families and youth, as well as system partners, will value what each brings to the table without judgment, meeting each where they are; 2) Equity: All members will have value and expertise in a particular area and all expertise is valued equally; 3) Reciprocity: Everyone gives and everyone receives, everyone learns and everyone teaches; there is the expectation that all members will give and receive in achieving the goals of the group; 4) Partnership: Families, youth, and systems partners will work together to find solutions that work well for everyone; groups will look for shared truth in achieving goals; 5) Empowerment: Families, youth, and system partners will refine skills to operate independently and improve advocacy efforts. System partners will also work to refine skills to embrace family-driven and youth guided practices.

FYSPRT involvement will be a critical partnership to assist in embedding youth and family voice in all components of this project. DBHR will continue to foster the developing environment of collaborative decision-making among the stakeholders. While responsible for the creation of this environment and keeping the discussion focused on the objectives of this effort, DBHR will honor the needs of each site to develop the most appropriate feedback mechanism for the youth and their families/caregivers. We are committed to establishing youth and family voice at all levels of policy development and services planning and delivery. As a result of this funding, and building on our previous efforts through the SOC and SAT-ED grant, youth and families/caregivers voices will be an integral part of the state's policy-making process.

Youth and families/caregivers will also be invited to participate in a Learning Collaborative to develop elements of a locally based Recovery Oriented Systems of Care. The Learning Collaborative will also offer a feedback loop necessary to understand if the selected assessment and family-centered EBP are meeting the needs of the youth and families/caregivers served and provide opportunity to improve the intervention based on their feedback.

D. 6. Continuous Quality Improvement

DBHR has a long-standing committed to continuous quality improvement to ensure the best possible service delivery to its clients. Quality reports are routinely developed that include both programmatic and administrative data. Detailed staff measures, data collection rates, treatment process measures, diagnostic and demographic information, service histories, service needs are presented in summary reports for the project as a whole and for each treatment site. These data are used for project management and continuous quality improvement in a way that is both family-driven and youth-guided. Members of the SOC and FYSPRT, as well as youth and their family members involved at the state level, work actively on the performance assessment and review the data from these reports quarterly.

In addition, RDA has a long history of conducting projects aimed at assessing and addressing racial disparities. All activities are completed in the most culturally competent manner possible. To accomplish this goal, RDA explicitly seeks input regarding the cultural appropriateness of research measures and methods. Gender, race, ethnicity, and geographic location are addressed in all analyses to quantify any disparities in impact of service delivery.

SECTION E: DATA COLLECTION AND PERFORMANCE MEASUREMENT

E. 1. Ability to Collect and Report

The performance assessment, including data collection, analysis and reporting, will be a collaborative effort between DBHR, RDA, and the treatment programs. DBHR and RDA have extensive experience successfully conducting SAMHSA funded program evaluations, including collecting and reporting federally required data for both mental health consumers and SUD treatment patients. Recent successful project efforts where such data (NOMS/GPRA) were gathered and reported include the SAMHSA-funded Screening, Brief Intervention and Referral to Treatment (SBIRT)[xvii], Access to Recovery (ATR)[xviii], and Washington Court and Recovery Enhancement System (WA-CARES)[xix] projects. Currently, DBHR and RDA are also collecting NOMS/GPRA data for the SAMHSA-funded Permanent Options for Recovery Centered Housing (PORCH; MHTG) and the Becoming Employed Starts Today (BEST) projects which focus on seriously mentally ill adults at risk of becoming homeless or unemployed respectively; the Bringing Recovery into Diverse Groups through Engagement and Support (BRIDGES) project, which applies the permanent supportive housing model to adults with substance abuse and chronic homelessness; and the SAT-ED project, which enhances treatment for youth with SUD.

Washington State was also a SAMHSA Mental Health Transformation Grant (MHTG-I; 2007-2011) grantee. A major component of the MHTG-I resulting infrastructure is the DSHS Integrated Client Database (ICDB; see *http://www.dshs.wa.gov/pdf/ms/rda/research/11/144.pdf*), built and maintained by RDA. This database extends back to July 1998 for all DSHS clients and includes services for over 2 million people per year. The foundation of the RDA integrated client database is a sophisticated matching algorithm that maintains a personal identifier crosswalk for service and event records derived from different administrative information systems. The database maintains the classification of social and health services into consistent service

modalities over time, which facilitates our planned multi-year cohort-based comparison group design. The database has been useful in estimating the prevalence of behavioral health risk factors from the combination of medical and behavioral health service events and arrest charges, and in measuring key life outcomes such as employment, criminal justice involvement, and medical service utilization and costs.[xx,xxi,xxii] Recent performance assessments utilizing the ICDB infrastructure have addressed: impacts of SUD treatment for GA-U clients on medical costs,[xxiii] impacts of SUD treatment on public safety,[xxiv, xxv] impact of ATR services on medical costs,[xxvi] and impact of SBIRT on substance use and treatment.[xxvii]

The data infrastructure in RDA, together with the technical and content expertise of RDA research and data staff and the successful performance assessment track record of DBHR, make this team extremely well suited for the WSYT-I performance assessment.

E. 2. Plan for Data Collection, Management, Analysis, and Reporting

The primary purpose of these performance assessment activities will be to improve outcomes for youth by measuring the impact of implementing evidence-based programs and expanding capacity for providing recovery support services to youth with SUD or COD. Another purpose will be to provide information useful to DBHR, FYSPRT, the Secretary of DSHS, and the Governor. This information will also be disseminated to the state and national treatment communities, and will provide SAMHSA with accurate and timely information on infrastructure and system changes and progress towards grant goals. The performance assessment will therefore address changes made in the statewide service system, as well as the impact of A-CRA and/or recovery support services for individual youth receiving these treatment enhancements.

Data sources will be both programmatic and administrative. The main programmatic data will be (1) a Youth Participant List, maintained by sites, that contains information about youths enrolling in WSYT-I; (2) the Common Data Platform (CDP), SAMHSA's online data-entry and reporting repository; and (3) GAIN assessment results. In addition to demographics (gender, age, race, and ethnicity), GPRA/CDP reporting categories will include abstinence from use, housing status, employment status, criminal justice system involvement, access to services, retention in services, and social connectedness. Program and administrative data, including medical encounter and state juvenile justice records, will also be used to track overall system performance and outcomes over time. This approach allows us to gauge the performance of the overall system, as opposed to only individual services provided by single providers.

CDP data will be collected by provider staff for youth receiving WSYT-I treatment enhancement in the five sites at baseline, discharge, and 6-months post-baseline. DBHR and providers will monitor response rates and provide incentives for follow up to ensure an intake and 6-month follow-up response rate of 80%. Upon collection of the data, grantees will have 7 business days to submit the data to SAMHSA's CDP data system. All data will be gathered by site program staff during face-to-face meetings and will be submitted to the CDP within 7 business days of collection.

Program data will also include GAIN data gathered via the Chestnut GAIN-ABS web-based system for the youth assessed with the GAIN. The GAIN-ABS system will generate reports that

will be used by providers administering the GAIN as a tool in treatment planning and quality improvement.

Additionally, for all events funded through the grant, including conference and learning collaborative sessions, data will be collected on overall satisfaction with event quality and application of event information using the appropriate CDP customer satisfaction tool. This data will be collected at the end of each event and at 30 days post-event from all participants.

E. 3. Additional Measures or Instruments

Administrative data are the information gathered as a function of receiving state services. These data are not being gathered as part of this project, but are components of the Integrated Client Databases that will be used for measuring outcomes. A set of measures will be developed, tested and reported to represent the individual and system changes and associated impacts (see table below). The primary source for this information will be the administrative records for youth contained in the RDA Integrated Client Databases (ICDB).

Administrative data will be used to monitor progress and outcomes for the population, as well as for participants receiving treatment service enhancements. Client data will include information about receipt of WSYT-I program enhancements (A-CRA and/or RSS) as well as behavioral health diagnoses, past and current services (both behavioral health and other types), criminal justice involvement, and child welfare system involvement. DBHR will incorporate the use of a special service code in their information system for the sites to identify A-CRA, which will allow tracking at the individual level. For prior projects, including SAT-ED, DBHR has constructed a Supports Activities table in TARGET, the statewide database for substance abuse treatment. RSS activities will be recorded by date in this table for a comprehensive view of service enhancement.

DBHR will also collect and report on the OMB approved state infrastructure measures that will reflect higher-level changes to the infrastructure system for youth substance treatment services.

E. 4. Continuous Quality Improvement

Reports will be developed that include both individual-level programmatic and administrative data as well as infrastructure measures. Detailed staff measures; data collection rates; treatment process measures; information on who was served, including diagnoses, demographics and service histories; services received as part of A-CRA; as well as service histories and service needs will be presented in summary reports for the project as a whole and for each site. Data will be used for project management and continuous quality improvement in a way that is both family-driven and youth-guided. Members of the WSSOCP and FYSPRT, as well as youth and their family members involved at the state level, will work actively on the Performance Assessment and review the data from these reports quarterly. RDA has a long history of conducting projects aimed at assessing and addressing racial disparities, and all activities will be completed in the most culturally competent manner possible. To accomplish this goal, the team will explicitly seek input regarding the cultural appropriateness of research measures and methods. Additionally, gender, race, ethnicity, and geographic location will be addressed in all

analyses to quantify any disparities in impact of WSYT-I treatment enhancements or access to care.

E. 5. Communication to Program Staff

Data will be used for implementation monitoring throughout the grant period, as well as for process and outcome evaluation. The project director will monitor the data collection and quarterly reports generated for the project, and summaries will be shared and reviewed regularly with the FYSPRTs and other key stakeholder groups. Measures will be reviewed in the context of how Washington is performing compared to the targets set and prior time periods with respect to:

- How closely does implementation follow the plan?
- Have EBP been adopted and disseminated statewide?
- In what ways is Washington moving toward a more coordinated effort to serve youth and their families? What are the drivers?
- Is capacity being increased? What has been the impact on health disparities in the population served?

The following outcome questions will also be addressed to the extent possible using a combination of program and administrative data.

- How has the array of publicly supported treatment and recovery services and supports for youth with SUD expanded over the grant period?
- What treatment/recovery services for youth with SUD were reimbursed by Medicaid/CHIP at the outset and conclusion of the project? Was there an increase?
- What treatment/recovery services for youth with SUD were reimbursed by other funding sources at the beginning and ending of the project? Was there an increase?
- To what degree has there been an increase in the number of clinicians trained, certified in EBP?
- How has the State identified barriers/solutions to widen the use of effective evidence based practices for youth and their families?

Data to address the questions above will be collected monthly by the project director and implementation sites will be required in contract to report this information to DBHR in a commonly defined spreadsheet. Additionally, RDA will review the system performance measures and programmatic data summaries with the WSYT-I project director continuously, with the statewide FYSPRT quarterly, and measures will be vetted through youth and family consumer groups in the regional FYSPRT roundtables. Each meeting of FYSPRT will include a report on data and performance monitoring activities relevant to the current stage of the grant.

E. 6. Performance Assessment Plan

In addition to the GPRA questions and process and outcome questions that will be addressed and reported to the project staff and stakeholders, a comprehensive performance assessment will address key components of the WSYT-I project and expected outcomes over time using a scientific and quasi-experimental approach to ensure meaningfulness of findings. Using the measures constructed in collaboration with FYSPRT and other youth and family partners, outcomes will be analyzed and reported for subgroups of youth with substance abuse as with

prior and current studies in Washington State that have documented behavioral health program impacts pertaining to treatment, arrests, employment, medical costs, housing stability, and education.

For performance assessment and ongoing implementation monitoring, RDA will construct a cohort of WSYT-I youth with substance abuse problems organized by month and state fiscal year. An operational database that includes participant information, demographic and geographic characteristics, services and dates, and specific information about behavioral health (e.g. COD, diagnoses, medications, services) will be constructed for the purpose of making meaningful comparisons over time. The outcome evaluation will use a quasi-experimental design and data from the ICDB to compare changes in key outcome measures for youth with substance abuse needs across three groups: (1) youth who receive publicly funded "treatment as usual"; (2) youth who receive "treatment as usual" plus recovery support services; (3) youth who receive evidence-based treatment (A-CRA) plus recovery support services.

Recent legislation in Washington state (2012 E2SHB 2536) prioritizes funding for evidence-based services and supports and tasks the Washington State Institute for Public Policy (WSIPP) to create an inventory of evidence-based, research-based, and promising practices for youth behavioral health and other services. In January 2014, WSIPP added recovery support services—the model used in Washington's SAT-ED project—as a "promising practice" to its "Inventory of Evidence-based, Research-based, and Promising Practices." Several research studies have demonstrated the positive effects of RSS on outcomes for adults receiving substance use treatment services. (e.g., Pringle et al. 2002[xxviii]; Krupski et al. 2009[xviii]; Wickizer et al. 2009[xxii]), and while it is expected that RSS may help youth in a similar manner, no rigorous studies to date have tested such a model. The structuring of the WSYT-I project in such a way that one group of youth (those who enroll in treatment services in the expansion site) get only the RSS treatment enhancement will provide the data to rigorously test the effects of RSS (apart from EBP/A-CRA), which will improve the chances for long-term sustainability of youth RSS in Washington State.

E. 7. Measurement of Change

For most outcome analyses we will use a *propensity score analysis* method to construct comparable groups of youth across the three treatment conditions with similar age, service histories, and criminal justice factors. This method incorporates numerous variables into a multivariate model that will generate propensity score weights that will be used to balance the three treatment groups on history of substance abuse and mental health problems and services, prior involvement with the criminal justice system, child welfare involvement, and demographic factors. This reduces *selection bias* by adjusting for pre-existing differences among groups. We will also conduct sensitivity analyses to assess the robustness of our findings. Comparisons among the three treatment groups ("treatment as usual"; "treatment as usual"+RSS; A-CRA+RSS) will be made and tested for statistical significance using a "difference in differences" approach.

The difference-in-differences approach [20] (also known as an untreated control group design with

pretest and posttest[xxix]) is often used to help control for expected changes that might occur given "treatment as usual." It compares the change in outcomes between the pre- and post-periods for youth who receive treatment enhancements relative to the change between the same periods for youth in the "treatment as usual" group. We will generally consider each month after WSYT-I begins to be the project "post" period for assessing the effects of change. Service start or an event parallel to program entry will be defined as the "WSYT-I index" for the "treatment as usual" group. Bivariate analyses will be conducted followed by regression models that control for remaining confounders to examine the impact of the treatment enhancements.

The need to rule out race, ethnicity, gender, and other demographic characteristics as potentially influencing outcomes and consideration of differential impacts between demographic groups will be essential in these analyses. We will address potential disparities in impact using descriptive analyses of treatment process measures such as treatment initiation, retention, engagement, and continuing care by race, ethnicity, and gender and by studying differential impacts of A-CRA and/or RSS in both the process and outcome analyses throughout the project.

PERFORMANCE MONITORING		
Measure	**Data Source**	**Sample/Comparison**
Infrastructure measures	DBHR program records	N/A
Training progress (number of sites / clinical staff certified to deliver A-CRA and RSS)	DBHR program records / administrative	All program sites
Enrollment progress	Youth participant list, GPRA/CDP, & administrative	All participants
Participant demographics (e.g., gender, age, race/ethnicity, GLBTQ)	GPRA/CDP & administrative	All participants
Other baseline participant characteristics (e.g., age at first use, COD, behavioral health diagnoses/prescriptions, prior behavioral health service history, prior service history of other types, child welfare involvement)	Administrative	All participants
A-CRA treatment services delivered (Type and number of sessions)	Administrative	All primary site (A-CRA+RSS) participants
Recovery support services provided (Type and number of sessions)	Administrative	All primary (A-CRA+RSS) and secondary ("treatment as usual" + RSS) site participants
Abstinence from use	GPRA/CDP	Change over time for primary site (A-CRA+RSS) participants
Housing status	GPRA/CDP	Change over time for primary site (A-CRA+RSS) participants
Employment status	GPRA/CDP	Change over time for primary site (A-CRA+RSS) participants
Juvenile justice involvement	GPRA/CDP	Change over time for primary site (A-CRA+RSS) participants
Access to services	GPRA/CDP	Change over time for primary site (A-CRA+RSS) participants

Retention in services	GPRA/CDP	Change over time for primary site (A-CRA+RSS) participants
Social connectedness	GPRA/CDP	Change over time for primary site (A-CRA+RSS) participants
OUTCOME EVALUATION		
Measure	**Data Source**	**Sample/Comparison**
Washington Circle Measures (initiation, engagement, retention)	Administrative	Treatment performance measures for primary site (A-CRA+RSS) and secondary site ("treatment as usual" + RSS) participants, compared to those for matched control group ("treatment as usual")
Juvenile justice involvement	Administrative	Changes over time for primary site (A-CRA+RSS) and secondary site ("treatment as usual" + RSS) participants, relative to change over time for matched control group ("treatment as usual")
Medical utilization (ER visits, Medicaid costs)	Administrative	Changes over time for primary site (A-CRA+RSS) and secondary site ("treatment as usual" + RSS) participants, relative to change over time for matched control group ("treatment as usual")
Educational outcomes (e.g., school enrollment, unexcused absences) *Contingent upon data availability.*	Administrative *Note: RDA has recently incorporated educational data into its data infrastructure and will determine the feasibility of including educational outcomes in the outcome evaluation.*	Changes over time for primary site (A-CRA+RSS) and secondary site ("treatment as usual" + RSS) participants, relative to change over time for matched control group ("treatment as usual")

SECTION F: JOB DESCRIPTIONS AND BIOGRAPHICAL SKETCHES

F. 1. Job Descriptions of Key Personnel

State Adolescent Treatment/Youth Coordinator

Working under the direction of the Children and Youth Behavioral Health Unit Supervisor, the State Adolescent Treatment/Youth Coordinator is instrumental in the oversight of substance use disorder treatment services to youth. This position manages statewide youth programs, maintains youth residential contracts, fiscal utilization, implements goals and strategies that carry out the agency's objectives in relation to youth treatment services. This is a full-time permanent position with duties that include:

1. Administers statewide policies and programs, including developing, managing, planning, organizing all youth SUD treatment services.
2. Serves as primary contact and treatment manager for youth and family substance use issues and represents the state at national conferences related to youth.
3. Interprets and operationalizes for department staff, contractors, and others, the goals, policies, regulations, and requirements related to youth treatment and other treatment services and programs.
4. Provides clinical supervision, technical assistance and training to the providers, staff, and referral sources of the WSYT-I project.
5. Maintains oversight of the provision of the selected evidence based intervention for SUD or COD and disseminate statewide.

Qualifications, Skills and Knowledge Required:

- Five years of professional, management experience delivering social services, medical and related care coverage funded by public programs.
- Knowledge of Evidence Based Practices for youth.
- Knowledge of substance use and mental disorders and the correlation between the two.
- Skill to link and coordinate with other child-serving systems.
- Successful development and implementation of new programs and services.
- Experience and proven skills in writing, verbal communication, grant development and management and use of multimedia formats.
- Experience managing and working with multiple systems and diverse interest groups while striving for goal-oriented positive change.

Supervisory Relationships:

This position reports to the Children's Behavioral Health Unit within DBHR.

Travel:

This position requires moderate travel both in state and out-of-state to conduct performance reviews, attend meetings, and meet grant requirements.

Salary Range: $60,000 - $90,000 per year

Hour per Week: 40

Project Director

This position reports to and works closely with the State Adolescent Treatment/Youth Coordinator. The position is responsible for the day-to-day operations of the WSYT-I project funded by SAMHSA grant, and as such, is a grant position. This position will work within the parameters of the national grant awarded to DBHR and is responsible for assuring that deliverables are met through the development of collaborative relationships, policies, operations and procedures and systems for reporting and tracking information. Duties include:

1. Brings together high-level representatives of stakeholders across the child-serving system.
2. Expands capacity of the workforce in the specialty sector and other child-serving agencies.
3. Develops and/or enhances a coordinated network of treatment and recovery support services for youth with SUD and/or COD and their families throughout the state.
4. Coordinates statewide trainings and meetings for WSYT-I according to the training plan submitted which includes GPRA, data collection, and evidence based interventions.
5. Identifies service gaps, develops and implements a statewide work plan, participates in infrastructure reform, policy development, and supports youth and family involvement at the policy and practice level.
6. Maintains oversight of budget utilization for the WSYT-I project and implements financial reform to improve the efficiency and integration of youth SUD and COD treatment, and recovery support system.
7. Monitors provider performance against contract, state, and federal requirements and establishes corrective action plans as necessary.
8. Prepares and submits federal reports that indicate results of program monitoring for compliance.

Qualifications, Skills, and Knowledge Required:

- Experience and proven skills in writing, verbal communication, grant development and management, and use of multimedia formats.
- Successful development and implementation of monitoring system for Limited English Proficiency program for DBHR.
- Ten years of experience managing contracts, fiscal controls, accounts payable, and accounts receivable.

Supervisory Relationships:

This position reports to the Children and Youth Behavioral Health Supervisor

Travel:

This position requires extensive travel both in state and out-of-state to conduct performance reviews, provide technical assistance, attend meetings, and meet grant requirements.

Salary Range: $60,000 - $80,000 per year

Hour per Week: 40

Evaluation Coordinator
The Evaluation Coordinator will, in collaboration with the Project Director, plan and manage all performance evaluation and report statistical analyses.

Qualifications, Skills and Knowledge Required:

- Advanced degree (Ph.D., Master's) in related health or social science or administration field.
- Specialization in data analysis and decision support.
- Prior experience in the following is desired: Program and process evaluation research methods, design, and modeling; knowledge and experience in conducting research regarding behavioral health program effectiveness; and Federal and state confidentiality requirements and human subjects protection rules for program evaluation and research.
- Excellent oral and written language and interpersonal skills.
- Ability to participate in a team environment.
- Understanding of policies relevant to behavioral health programs in Washington State.

Supervisory Relationships:
The Evaluation Coordinator is an external evaluator and as such will be under contract with DBHR. For this project, the Evaluation Coordinator will report to the Project Director.

Travel:
This position requires minimal travel. The Evaluation coordinator is expected to travel to Washington DC one time per year to attend a 3-day national grantee meeting.

Salary Range: $70,000 - $100,000 per year

Hour per Week: 40

F. 2. Curricula Vitae of Key Personnel

State Adolescent Treatment/Youth Coordinator: Diana Cockrell, CDP

Diana Cockrell

Work Experience

2015 – Current Washington State Division of Behavioral Health and Recovery
Youth Behavioral Health Treatment Lead

- Policy development and implementation focused on Youth services
- Manage marijuana tax revenue funds allocated toward youth intervention, treatment, and recovery supports
- Support and partner with the Children's Behavioral Health team to move toward integration of behavioral health services.

2015 – 2015 Thurston County Public Health & Social Services
Thurston/Mason Behavioral Health Organization (BHO) Development Analyst

- Policy development and implementation
- Develop co-occurring programs, provider networks
- Maintain and grow substance use disorder treatment and prevention services
- Work in tandem with the BHO Manager developing contracts, oversight, budget, care management, and compliance.

2014 – 2015 Thurston County Public Health & Social Services
Chemical Dependency Program Interim Manager

- Administer program budget and contracts, for substance use prevention, intervention, treatment and aftercare for low income adult and youth outpatient services including: detoxification, involuntary commitment, therapeutic courts, Criminal Justice Treatment Act, intensive case management, opiate replacement therapy, community prevention redesign, and recovery supports in a two county region.

2012 – 2014 Thurston County Public Health &Social Services
Treatment and Prevention Specialist

- Craft statements of work for contracting with licensed chemical dependency agencies for adult and youth outpatient services, detoxification, involuntary commitment, therapeutic courts, intensive case management, and medication assisted therapy (opiate substitute therapy).
- Ensure contract compliance through onsite reviews and technical assistance.

2001 - 2012 Providence St. Peter Hospital Lacey, WA
Clinical Supervisor, Adolescent Outpatient Services

- Developed, managed, and provided treatment for Thurston County Juvenile Drug Court program including: managing budget for urinalysis, contract compliance, system improvement, and utilization.
- Clinical Supervision for Adolescent Outpatient and Juvenile Drug Court Services
- Community connection and outreach

Diana Cockrell

Chemical Dependency Professional (CDP) and Internship

- Assessment, placement, group, multi family therapy, coordination of care, and individual counseling.
- Juvenile Drug Court Team building, responsible for the treatment component.
- Outreach partnerships with schools, and local youth serving agencies.
- Emergency Department (ED) specific: Washington State Screening, Brief Intervention, and Referral to Treatment (WASBIRT) with Motivational Interviewing therapy focus.

Specialty Training

- **Certified Youth Mental Health First Aid Trainer**
- **Technology Based Clinical Supervision Trainer**
- **Motivational Interviewing**
- **Dialectical Behavioral Skills**
- **Licensed Chemical Dependency Professional**

Education

BA Human Development, Minor in Psychology
2009 – December 2011 Washington State University Pullman, Washington

MA Psychology- Counseling
Current – 2016 Brandman University

Speaking Engagements

Washington State Co-Occurring Conference 2015
Building a Youth Recovery Oriented System of Care – Lessons Learned

Substance Abuse: A Community Response Conference 2013, 2014, 2015
Juvenile Drug Court, Party Intervention Patrol, Youth Recovery Oriented Systems of Care

First Responder Employment Education Series, 2014
Compassion Fatigue and Coping Well

Quinault Indian Nation Treatment/ /Prevention Summit 2011
Collaboration and Balancing Substance Use Treatment and the Court process in Juvenile Drug Court

Lunchtime Education at Family and Juvenile Court, 2012
Juvenile Drug Court Program

Awards

Making a Difference in the Life of a Child Award, Thurston Community Network, 2012

Phoenix Award, Behavioral Health Resources, 2010

Thelma B. Passionate Youth Professional Award, Division of Alcohol and Substance Abuse, 2008

Champion for Children, TOGETHER! 2007

Volunteer

Chair- Lacey Fire District 3 Citizens Advisory Committee 2014-present
Executive Committee Tour de Lacey Gateway Rotary Fun Ride 2015

Project Director: Pedro Garcia, MPA

EDUCATION

2012–2014 The Evergreen State College **Olympia, WA**
- Master of Public Administration

1990–1995 The University of California at Berkeley **Berkeley, CA**
- Bachelor of Arts

SKILLS

- Familiar with Washington's legislative directives to integrate services across multiple systems
- Knowledgeable of current issues related to youth and families
- Understanding of agency-wide client populations and service delivery structures
- Experience managing workgroups of diverse audiences and cross-system teams
- Experience in program management and staff supervision
- Effective communication with varied networks of internal and external stakeholders
- Proficient in budgeting, management, and scheduling practices
- Knowledge of data collection, research, and policy analysis

PROFEFSSIONAL EXPERIENCE

2014-Present Children's Behavioral Health Unit **Lacey, WA**
Recovery Youth Services Program Director
- Develop and manage the Recovery Youth Services program and SAT-ED grant
- Ensure compliance with federal and funding and program reporting requirements
- Ensure statewide implementation of selected evidence-based practices
- Provide guidance and leadership to SUD treatment providers, including workforce development
- Monitor provider performance and compliance with state and federal standards
- Collaborate with other child-serving agencies to promote integrated SUD treatment services

2013-2014 Office of Service Integration **Lacey, WA**
Quality Assurance Contracts Specialist
- Develop and negotiate service contracts for the Health Home and HealthPath Washington programs
- Maintain quality assurance oversight of work performed by Qualified Health Homes
- Conduct compliance audits that focus on adherence to state and federal standards
- Work with diverse groups of service providers to identify and resolve delivery barriers
- Implement corrective actions to improve the overall experience of service recipients

2007-Present Division of Behavioral Health and Recovery **Lacey, WA**
RSN Contracts Manager
- Responsible for the oversight of state contracts with Regional Support Networks
- Served as lead worker providing training and technical assistance to contract staff
- Drafted and negotiated contract language for the provision of mental health services
- Researched, developed, and implemented client outcomes measures
- Monitored contractor compliance with state and federal requirements
- Managed federally mandated external quality review activities

2004-2007 Community Youth Services **Olympia, WA**
Foster Home Licensor and Quality Manager
- Recruited, trained, and supervised foster families
- Assisted perspective foster parents in completing the licensing process
- Conducted site inspections of new and existing foster homes
- Trained clinical case managers in documentation standards
- Ensured agency records complied with clinical requirements

2003-2004 Selma R. Carson Home Fife, WA
Education Program Supervisor
- Designed and implemented a pilot education program for unacompanied immigrant youth
- Developed policies and procedures that comply with state education standards
- Provided leadership for the accreditation process of the program
- Assessed the academic skill level of Spanish-speaking students

2002-2003 Healthy Families of Clallam County Port Angeles, WA
Family Preservation Therapist
- Maintained a caseload of up to 25 clients from different socio economic backgrounds
- Assessed child and family strengths and areas of improvement
- Developed and implemented goal-oriented service plans
- Performed clinical social work duties, including counseling and education
- Provided interventions intended to reduce the risk of child abuse and neglect

2001-2002 Healthy Families of Clallam County Port Angeles, WA
Lead Teacher and Clinical Supervisor
- Maintained oversight of the agency's family development center
- Trained and supervised clinical staff
- Developed pre-school curricula for foster children ages of 2-6
- Provided counseling and education to natural parents participating in the program
- Conducted home visits and helped clients to connect with community resources

1998-2000 Headlands Institute Sausalito, CA
Field Science Teacher
- Collaborated with local school districts to develop outdoor science curricula
- Conducted public education workshops on local geology, native plants, and common wildlife
- Planned and facilitated wilderness-therapy expeditions of up to three weeks for at-risk youth

1995-1998 CYO Caritas Creek Occidental, CA
Field Science Teacher
- Developed and implemented outdoor science curricula for youth in grades K-12
- Conducted public awareness and education workshops on local environmental issues
- Directed high and low ropes course events for at-risk youth
- Facilitated wilderness therapy expeditions of up to one week for at-risk youth

HONORS RECEIVED:
n/a

RECENT PUBLICATIONS:
n/a

Evaluation Coordinator: Barbara A. Lucenko, Ph.D.

POSITION TITLE
Chief, Program Research and Evaluation Section
Washington State Department of Social and Health Services, Research and Data Analysis Division (RDA)

EDUCATION/TRAINING	DEGREE	YEAR	FIELD OF STUDY
University of Delaware, Newark, DE	B.S.	1990	Business Administration
Nova Southeastern University, Davie, FL	M.S.	1995	Mental Health Counseling
University of Washington School of Medicine, Seattle, WA	Clinical Internship	2000	Psychiatry & Behavioral Sciences
Nova Southeastern University, Davie, FL	Ph.D.	2000	Clinical Psychology
University of Miami School of Medicine, Miami, FL	Postdoctoral Fellowship	2002	Psychiatry & Behavioral Sciences

A. Personal Statement

I am a clinical psychologist with over a decade of applied health services research experience. My specialty is research and program evaluation relevant to behavioral health for complex clients receiving publicly funded services. I have held positions that focus primarily on clinical outcomes and health services in diverse settings such as community mental health treatment programs, university and military medical centers and as a senior-level research manager in state government. Interests and project topics have included HIV/AIDS prevention and health risk behavior, specialty court evaluation, posttraumatic stress, and co-occurring disorders.

B. Academic and Professional Positions and Clinical Training

Positions and Employment

1993-1994	Courthouse Intake Counselor, Women in Distress Outreach Center, Broward County Courthouse, Ft. Lauderdale, FL
1994-1996	Special Project Coordinator and Research Assistant, Center for the Study of Youth Policy, Nova Southeastern University Law Center, Davie, FL
1995-1996	Research Assistant, Child and Adolescent Traumatic Stress Program, Nova Southeastern University, Davie, FL
1996–1997	Research Assistant, Sexual Abuse Survivors Program, Nova Southeastern University, Davie, FL
1997–1999	Statistical and Testing Consultant, Computer and Testing Lab, Nova Southeastern University, Davie, FL
1996-1999	Adjunct Professor, Broward Community College, Behavioral Sciences, Fort Lauderdale, FL
1997-1999	Research Coordinator, Trauma Resolution and Integration Program, Nova Southeastern University, Davie, FL
2000-2002	Postdoctoral Fellow/Assistant Scientist, University of Miami School of Medicine, Psychiatry & Behavioral Sciences, Miami, FL
2002–2004	Senior Research Specialist, Washington State Center for Court Research, Administrative Office of the Courts, Olympia, WA

2004-2006	Research Psychologist, Madigan Army Medical Center, Psychology, Tacoma, WA
2006-2007	Research Administrator, Evaluation & Quality Assurance, Department of Social and Health Services, Division of Alcohol and Substance Abuse, Olympia, WA
2005-	Clinical Instructor, Department of Psychiatry and Behavioral Sciences, University of Washington School of Medicine, Seattle, WA
2008-	Senior Research Manager/Chief, Program Research and Evaluation Section, Department of Social and Health Services, Research and Data Analysis, Olympia, WA

Professional Licenses and Clinical Training

1995-1998	Clinical Practica, Nova Southeastern University, Davie, FL
1999-2000	Psychology Resident, Community/Corrections Psychology Track, University of Washington School of Medicine, Department of Psychiatry and Behavioral Sciences, Seattle, WA
2002-	Licensed Psychologist, State of Florida, PY6521
2004-	Licensed Psychologist, State of Washington, PY2930

Editorial Activities and Faculty Positions

2000-	Journal Reviewer, Psychological Trauma: Theory, Research, Practice and Policy
2004-2006	Faculty, Psychology Residency Program, Madigan Army Medical Center, Tacoma, Washington
2006-	Ad Hoc Reviewer, Journal of Traumatic Stress

Boards and Committees

2003-	State of Washington Research Subcommittee of the Citizens' Advisory Council on Alcoholism and Drug Addiction
2006-	State of Washington Mental Health Transformation (I-II) Evaluation Team
2010-	Washington State Integrated Case Management Steering Committee
2012-	Washington State Center for Court Research Advisory Board

C. Selected Publications

SELECT PEER REVIEWED PUBLICATIONS

Lucenko, B.A., Sharkova, I.V., Huber, A., & Mancuso, D.M. (under review). Adverse childhood experiences and behavioral health during adolescence: An investigation using administrative data.

Maguen, Shira, **Lucenko, B.A.,** Reger, M.A., Gahm, G.A., Litz, B.T., Seal, K.H., Knight, S.J., & Marmar, C.R. (2010). The impact of reported direct and indirect killing on mental health symptoms in Iraq War. *Journal of Traumatic Stress, 23,* 86-90.

Lipsky, S., Krupski, A., Roy-Byrne, P., **Lucenko, B.A.,** Mancuso, D., & Huber, A. (2010). Effect of co-occurring disorders and intimate partner violence on substance abuse treatment outcomes. *Journal of Substance Abuse Treatment,* 38, 231-244.

Krupski, A., Campbell, K., Joesch, J.M., **Lucenko, B.A.,** & Roy-Byrne, P. (2009). Impact of Access to Recovery services on alcohol/drug treatment outcomes. *Journal of Substance Abuse Treatment, 37,* 435-442.

Evaluation Coordinator: Bridget J. Lavelle, Ph.D.

Bridget J. Lavelle, Ph.D.
(360) 902-0741
Senior Research Manager for Social and Health Services
lavelbj@dshs.wa.gov

INSTITUTION AND LOCATION	DEGREE	YEAR	FIELD OF STUDY
Grinnell College, Grinnell, IA	B.A.	2004	Mathematics and Sociology
Iowa State University, Ames, IA	M.S.	2008	Statistics
University of Michigan, Ann Arbor, MI	M.A.	2010	Sociology
University of Michigan, Ann Arbor, MI	Ph.D.	2013	Public Policy and Sociology

PROFESSIONAL POSITIONS

2012-present ***Senior Research Manager for Social and Health Services, Program Research and Evaluation Section***
Department of Social and Health Services, Research and Data Analysis
Olympia, Washington

2008-2012 ***Research Assistant***
National Poverty Center, University of Michigan

2007-2008 ***Research Assistant***
Institute for Social and Behavioral Research, Iowa State University

2006-2007 ***Research Assistant***
Center for Survey Statistics and Methodology, Iowa State University

2004-2006 ***Research Analyst, Senior Research Assistant, and Research Assistant***
Child Trends, Washington, DC

ACTIVITIES AND COMMITTEES

2013-Present Washington State Children's Behavioral Health Data Quality Team

2013-Present Ad Hoc Reviewer, *Population Research and Policy Review*

2011–Present Ad Hoc Reviewer, *Journal of Marriage and Family*

PEER REVIEWED PUBLICATIONS

Lavelle, B. and Smock, P. (2012). Divorce and women's risk of health insurance loss. *Journal of Health and Social Behavior*, 53, 413-431.

Lavelle, B., Lorenz, F.O., and Wickrama, K.A.S. (2012). What explains divorced women's poorer health?: The mediating role of health insurance and access to health care in a rural Iowan sample. *Rural Sociology*, 77, 601-625.

Lavelle, B., Larsen, M., and Gundersen, C. (2009). Research synthesis: Strategies for surveys of American Indians. *Public Opinion Quarterly*, 73, 385-403.

Hair, E., Halle, T., Terry-Humen E., Lavelle, B. and Calkins, J. (2006). Children's school readiness in the ECLS-K: Predictions to academic, health, and social outcomes in first grade. *Early Childhood Research Quarterly*, 21, 431-454.

SELECT RECENT PRESENTATIONS

Lavelle, B. (2012). Job loss and health insurance in the Great Recession: Evidence on the ARRA COBRA subsidy from the Survey of Income and Program Participation. Invited presentation to Agency for Healthcare Research and Quality, November 7.

Lavelle, B. (2012). Inequality and health. Guest lecture for Poverty and Social Welfare (Public Policy 736), University of Michigan, October 12.

Lavelle, B. (2012). Maintaining health insurance after layoff during the Great Recession: Evidence on the ARRA COBRA subsidy from the Survey of Income and Program Participation. Association for Public Policy Analysis and Management Fall Research Conference, November 5.

Lavelle, B. and Smock, P. (2010). Divorce and women's risk of health insurance loss. Survey of Income and Program Participation (SIPP) Analytic Research Conference, U.S. Census Bureau, September 27.

Lavelle, B., Lorenz, F., and Opsomer, J. (2007). A study of pathways from divorce to illness. Annual Joint Statistical Meetings, July 29.

SELECT GOVERNMENT REPORTS

Lavelle, B., Mancuso, D., Huber, A., and Felver, B. (2014). Expanding eligibility for the Family Caregiver Support Program in SFY 2012: Updated findings. DSHS Research and Data Analysis Division, Report 8.31.

Lavelle, B., Mancuso, D., Felver, B. (2014). Washington State's Fostering Well-Being Program: Impacts on medical utilization. DSHS Research and Data Analysis Division, Report 9.105.

Zaslow, M.K., Tout, K., Halle, Whittaker, J.V., and Lavelle, B. (2010). Towards the identification of features of effective professional development for early childhood educators. Prepared for Office of Planning, Evaluation, and Policy Development, U.S. Department of Education. Washington, DC: Child Trends.

Halle, T., Zaslow, M., Lavelle, B., and Wandner, L. 2006. Early Learning Opportunities Act evaluation in the District of Columbia: Year 1 final report. Prepared for the District of Columbia Department of Human Services. Washington, DC: Child Trends.

Pittard, M., Zaslow, M., Lavelle, B., and Porter, T. 2006. Investing in quality: A survey of state Child Care and Development Fund initiatives. Washington, DC: American Public Human Services Association and Child Trends.

SECTION G: CONFIDENTIALITY SAMHSA PARTICIPANT PROTECTION

G. 1. Protect Clients and Staff

Foreseeable risks or potential adverse effects and procedures for minimizing risk: The potential physical, medical, psychological, social, legal or other risks that clients may face by participating in WSYT-I project or through related monitoring and assessment activities are listed below. Next to each listed risk is a description of steps the project team will take to minimize risk.

Youth may feel coerced to participate. This project is designed to serve youth ages 12 to 18 receiving publicly funded SUD treatment in community-based provider agencies. Most of these youth are low-income and publicly insured. They may feel they must participate in order to receive services. In Washington State, at age 13, youth must provide written consent to all behavioral health treatment, with or without their parents' consent unless treatment is being provided under the involuntary treatment act (RCW 71.34.700) or as the result of a parent-initiated evaluation (RCW 71.34.600). In this project, the engagement of families and natural supports is integral to the process, but their participation is strictly voluntary. The Authorization form for participation in this project will be signed in addition to the consent for treatment form that the youth must sign (or parents of 12-year-old participants) to receive treatment. While the target population of this project is 12 to 18, all of the assurances in this section apply to any youth under the age of 18 and their family and legal guardian who must provide consent for treatment and authorization for participation.

To minimize the risk of coercion, staff will use a standard script to ensure that the youth and their family are informed about the project and know that their participation is voluntary. Each youth will be given an overview of what participation entails, including the types of questions they will be asked if they participate. Youth will also be told that their receipt of any program services will not be affected by their decision about whether or not to participate in the project. Since the project is being conducted with oversight from the state's DSHS, DBHR and RDA, clients will also be assured that their decision about participation will not affect any DSHS benefits that the individual or members of his or her family may receive.

Youth or family may feel discomfort in responding to the Government Performance and Results Act (GPRA) questions. To minimize this risk, all questions will be asked by Care Coordinators trained and experienced in working with youth and families. They will follow agency policies on working with a youth, being sensitive to the possible reactions, and safeguarding the youth's rights to privacy and confidentiality. Staff will seek a place within the agency where the GPRA can be conducted in private, so that a youth is not asked about personal behavior in a place where others can readily hear his or her answer.

Breach of confidentiality of treatment and GPRA questionnaire data. All clinic staff working on the project will be reminded of strict guidelines about how to maintain the confidentiality of patient data. GPRA intake, discharge, and follow-up surveys will be electronically transmitted by clinic staff directly via SAMHSA's secure website. Since this process does not require the transmission of personal identifiers, youth cannot be directly identified during this electronic transmission or within the *federal* CDP data files. Project staff in the agencies will also transmit

screening and GPRA intake questionnaire data to DSHS staff for monitoring and reporting; however, they will use a tracking number that does not contain personal identifying information. The link between the tracking number and patient identifiers (e.g., name, DOB, social security number) will be maintained on a Youth Participant List by agency staff on a password-protected computer system and/or in locked filing cabinets. It will be transmitted to project monitoring and assessment staff at DSHS, separately from screening and questionnaire responses, using a secure means (e.g., encrypted e-mail or using Secure File Transfer Protocols).

Accidental release of information from administrative data to be used in outcome analyses. This is a potential risk for youth and families involved in the project. To minimize this risk, all administrative data will be stored *on* RDA network servers and personal computers that incorporate security protections to ensure that only approved staff have access to the data. All necessary data sharing agreements will cover issues such as how the data can be used, restrictions against re-disclosure, and how data should be stored. Project staff will be required to read and sign confidentiality statements that accompany data sharing agreements for each data source. RDA staff has extensive experience in protecting the confidentiality of client-level administrative data in many prior studies conducted for DBHR and other DSHS programs. The use of the administrative data for outcome analyses will receive the appropriate level of human subjects' protection review, as determined by the Washington State Institutional Review Board (WSIRB) (DSHS FWA00000326). This will help ensure that the procedures adopted by project staff comply with high standards designed to protect privacy and minimize the risk of breaches of confidentiality. In addition, the evaluation team will have up-to-date training in human subjects' protection.

Protocol to address adverse effects, crisis situations, and expressed needs. As part of the training that staff receives for the project, they will be given guidelines for identifying signs of discomfort or more serious forms of adverse reactions that patients may exhibit as a result of the questions asked or further discussions that might result. As experienced professionals in the field of behavioral health counseling, project staff will be able to use their professional judgment to either wait briefly before continuing or simply ending the interview, or discussing and addressing the issues that have arisen for the patient after the interview is complete. In some cases, patients may need immediate assistance or referrals for further services. The project will occur in existing community-based provider agencies which have procedures in place for tasks such as crisis intervention and linking patients to needed resources and supports in the community. As such, project staff will have a full set of local resources and information about how to contact those resources. This will ensure that patients get an appropriate level of assistance in the event they experience adverse effects as a result of their participation in the project.

Alternative treatments that may be beneficial for participants. Although the project is specifically designed to address youth with multiple needs and their families, it is possible that other treatment needs not available at the provider agency could be identified while completing the GPRA interview. If this occurs, the staff will refer the youth to appropriate local resources

where the person could obtain needed treatment. This could include referrals to physicians, mental health professionals, dentists, other recovery support services, or other types of providers.

G. 2. Fair Selection of Participants

Population to be served. The participants will be community SUD agency youth between the ages of 12 and 18. Youth of any racial or ethnic background will be eligible for participation in the project. Both males and females will be served. The youth served may include homeless youth, children in foster care, children of substance abusers, and pregnant women. Youth with SUD often come from troubled families. They are significantly more likely than their peers to have parents who abuse or neglect them; who abuse substances themselves; or who have a history of conviction/arrest (Lucenko et al. 2012[xxx]).

In those counties where a large proportion of individuals served by the provider partners have limited English proficiency, either bilingual staff or an interpreter will be available. In addition to interpretation services, ASL will be available for individuals with hearing loss.

Reasons for selection priorities. The WSYT-I project builds on an existing program for SUD and mental health disorder services already in place statewide under DBHR contracts. Many youth in the project will have multi-system involvement and/or out of home placement, but that is not a requirement for participation. There is no prioritization based on race or ethnicity.

Recruitment and selection of participants. We will prioritize youth with COD, youth involved in multiple systems such as child welfare and juvenile justice and attention will also focus on behavioral health disparities impacting racial and ethnic groups; lesbian, gay, bisexual, transgender and questioning (LGBTQ) individuals. They will be referred by the professional who conducts the intake based on the youth's assessed needs.

G. 3. Absence of Coercion

Participation in the WSYT-I project will be completely voluntary. As described in item 1 above, the care coordinator will be responsible for explaining that participation in all aspects of this project is voluntary. To ensure that this message is conveyed clearly, the Evaluation Coordinator will train project staff in the methods for recruiting participants in the project and for explaining the gathering of GPRA data and the use of administrative data (see item 1 above).

G. 4. Data Collection

There are several components to the data collection process for this project.

Assessment. All youth in the WSYT-I project's primary clinical sites will be assessed using the GAIN at intake and GAIN-M90 at 3- and 6-month follow-up. Assessment scores for participants will be submitted to Chestnut's secure data system. The data will contain a de-identified client tracking number.

GPRA data. Baseline and follow-up (6 month time-point and discharge) GPRA data will be obtained for youths in the WSYT-I project's primary clinical sites through in-person interviews conducted by clinical staff. GPRA data will be electronically transmitted directly to SAMHSA via the secure website (Common Data Platform) using a de-identified client tracking number to

enable its linkage to administrative data for program monitoring purposes. GPRA data will be maintained on secure password-protected RDA servers to ensure that only approved staff members have access to the data.

Client identifiers for linking to administrative data and contact information for GPRA follow-up. Clinical staff will collect identifying information from patients in the clinics. Information linking the client tracking number to client identifiers (e.g., name, DOB, SSN) will be maintained by project staff in the clinics on a password-protected computer system and/or in locked file cabinets, and will be transmitted to RDA staff for outcomes monitoring and GPRA reporting using a secure means (e.g., encrypted e-mail, secure file transfer protocol).

Substance use "encounter" data from DBHR's TARGET data system (statewide database for publicly funded substance abuse treatment) and from Chestnut's EBTx data system (secure database for A-CRA treatment session information) will identify youth served, dates of service, and number of sessions. This information will be collected and stored securely on each client served, to permit linkage to client-level administrative data for outcomes monitoring and performance assessment. This information will be transmitted to RDA for analysis by secure file transfer protocols meeting information technology standards.

Data from administrative records. Client-level administrative data will be analyzed for youth participating in the WSYT-I project, as well as for DSHS clients in the comparison group we will create for purposes of evaluation. Recovery support services data will identify the types and dates of recovery support services received by individual clients. All necessary data sharing agreements will be developed to cover issues such as how the data can be used, restrictions against re-disclosure, and how data should be stored. Project staff will be required to read and comply with data sharing agreements that accompany each data source. All administrative data will be stored on RDA network servers and personal computers that incorporate security protections to ensure that only approved staff have access to the data.

Other data. No urine, blood, or other specimens will be collected.

G. 5. Privacy and Confidentiality

Chemical Dependency Professionals or other clinical/case management staff at provider agencies will be in direct contact with participants in order to ascertain the level of need, to provide referrals to services, and to assist in gaining access to needed treatment and other services. Staff training will include extensive information on the importance of maintaining the confidentiality of client data, particularly under laws governing SUD and mental health treatment. In addition, the WSYT-I Project Director in DBHR and RDA will provide specific training to staff regarding correct procedures for gathering, storing, and transmitting confidential data that will comply with provisions of Title 42 of the Code of Federal Regulations, Part II. All staff involved with clients in the WSYT-I project will also be trained in the importance of maintaining the confidentiality of patient data.

Procedures will be designed to protect the confidentiality of information gathered for clinical and case management purposes, including encounter data (services received and dates). These will

include storage of paper records and clinical notes in locked file cabinets and the use of secure data transfer systems for entering data into required databases, including the web-based GPRA data entry system. In addition, training for staff involved with this project will include the use of appropriate authorization forms to permit the sharing of information with other service providers and with the RDA evaluation staff. All WSYT-I project staff will be given instructions about the risks of using emails between agencies that fall outside secure firewall protections as emails being an unacceptable means for exchanging confidential information.

Designated staff will collect the following data from WSYT-I participants.

1. GAIN Assessment data.
2. Intake GPRA data.
3. Encounter information (services received and dates).
4. Recovery support services information
5. Client identifiers for linking to administrative data.
6. Follow-up GPRA data.
7. Discharge GPRA data.

Information linking the client tracking number to client identifiers (e.g., name, DOB, SSN) will be maintained on-site on a password-protected computer system and/or in locked file cabinets and will be transmitted to RDA staff for outcomes monitoring and reporting using a secure means (e.g., encrypted e-mail, hand collection by RDA staff). Assessment and GPRA data sent to RDA will not include client identifiers, but rather the de-identified client tracking number.

GPRA follow-up data will be collected in person by care coordinators. GPRA follow-up data will be input into the secure SAMHSA site.

The RDA evaluation team that will be monitoring performance and assessing outcomes has extensive experience in protecting the confidentiality of client-level administrative data based on a number of prior studies conducted for DBHR and other divisions within DSHS. All data will be stored on RDA network servers and personal computers that incorporate security protections to ensure that only approved staff have access to client-level data with personal identifiers. Personal identifiers will be stored in separate tables and will be linked to analytical data files with an assigned identification number.

G. 6. Adequate Consent Procedures

Information Provided to Project Participants. To assist behavioral health professionals who will be conducting the assessment and gather GPRA data and provide referrals to treatment and support activities, we will develop a standard script for them to use when introducing themselves and the project to prospective WSYT-I participants. The script will provide the following information:

- Purpose, risks, and benefits of participation.
- What data will be collected for the evaluation of the project.
- How the data will be used.

- How data will be kept private to protect confidentiality.
- Participation is voluntary.
- Participants may withdraw without penalty.
- Possible risks and plans to protect against these.

Procedures for Persons with Limited Reading, English-speaking or hearing loss. For persons with limited reading skills limited English speaking, or hearing loss, the Chemical Dependency Professional will be instructed to read any written materials to participants and provide answers to questions, whenever needed. For persons with limited English proficiency, pre-translated assessment instruments in the patient's primary language will be used, whenever possible, and interpretation services including ASL will be provided (in-person or by phone).

G. 7. Risk/Benefit Discussion

By using the procedures described above, we believe the risks to participants will be minimized. We believe the benefits of this project far outweigh the risks, with its potential to achieve outcomes through the use of EBPs (A-CRA) and recovery support services.

CITATIONS

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[i] *Improving the Statewide Adolescent Treatment System of Care,* Olympia, DSHS-DASA: 2007

[ii] Godley, M.D., Godley, S.H., Dennis, M.L., Funk, R., & Passetti, L.L. (2002). Preliminary outcomes from the assertive continuing care experiment for adolescents discharged from residential treatment. *Journal of Substance Abuse Treatment, 23,* 21–32.

[iii] White, W. (2008). *Recovery Management and Recovery-oriented Systems of Care: Scientific Rationale and Promising Practices.* Pittsburgh, PA: Northeast Addiction Technology Transfer Center, Great Lakes Addiction Technology Transfer Center, Philadelphia Department of Behavioral Health & Mental Retardation Services.

[iv] Kaplan, L., *The Role of Recovery Support Services in Recovery-Oriented Systems of Care.* DHHS Publication No. (SMA) 08-4315. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 2008.

[v] Azrin, N.H., Sisson, R.W., Meyers, R.J., & Godley, M.D. (1982). Outpatient alcoholism treatment by community reinforcement and disulfiram therapy. Journal of Behavior Therapy and Experimental Psychiatry, 13, 105-112.

[vi] Hunt, G.M., & Azrin, N.H. (1973). A community-reinforcement approach to alcoholism. Behavior Research and Therapy, 11, 91-104.

[vii] Smith, J.E., Meyers, R.J., & Delaney, H.D. (1998). The community reinforcement approach with homeless alcohol-dependent individuals. Journal of Consulting and Clinical Psychology, 66, 541-548.

[viii] Meyers, R.J., & Smith, J.E. (1995). Clinical guide to alcohol treatment: The Community Reinforcement Approach. New York: Guilford Press.

[ix] Godley, S.H., Hedges, K., & Hunter, B. (2011). Gender and racial differences in treatment process and outcome among participants in the Adolescent Community Reinforcement Approach. Psychology of Addictive Behaviors 25, 143-154. doi:10.1037/a0022179.

[x] Hunter, B.D., Godley, S.H., Hesson-McInnis, M., & Roozen, H.G. (2012). A longitudinal analysis of change mechanisms for substance use and illegal activity: Exposure to the Adolescent Community Reinforcement Approach. Manuscript submitted for publication.

[xi] Slesnick, N., Prestopnik, J.L., Meyers, R.J., & Glassman, M. (2007). Treatment outcome for street-living, homeless youth. Addictive Behaviors, 32, 1237-1251.

[xi] Kohlenberg, L., Lucenko, B., Mancuso, D., He, L., Coker, L., Liu, Q., and Felver, E. M. 2013. *Behavioral health needs and school success, youth with mental health and substance abuse problems are at risk for poor high school performance.* Olympia, WA, Department of Social and Health Services Research and Data Analysis

[xiii] Dennis, M. L., Titus, J. C., White, M., Unsicker, J., & Hodgkins, D. (2003). *Global Appraisal of Individual Needs (GAIN): Administration guide for the GAIN and related measures.* (Version 5 ed.). Bloomington, IL: Chestnut Health Systems. Retrieved from www.gaincc.org on January 17, 2012.

[xiv] American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders version 4 text revised (DSM-IV-TR).* Washington, DC: American Psychiatric Association

[xv] American Society of Addiction Medicine (ASAM). (2001). *Patient placement criteria for the treatment for substance-related disorders* (2nd ed.). Chevy Chase, MD: American Society of Addiction Medicine.

[xvi] Joint Commission on Accreditation of Healthcare Organization (JCAHO). (1995). *Accreditation manual for mental health, chemical dependency, and mental retardation/developmental disabilities services: Standards.* Oakbrook Terrace, IL: Author.

[xvii] *The Washington State Screening, Brief Intervention, Referral and Treatment (WASBIRT) Project.* Olympia: DSHS; May 07. 4.60.

[xviii] Krupski A, Campbell K, Joesch JM, Lucenko BA, Roy-Byrne P. Impact of Access to Recovery services on alcohol/drug treatment outcomes. *J Subst Abuse Treat.* Dec 2009;37(4):435-442.

[xix] Lucenko BA, Henzel PD, Black C, Mayfield, J, Felver BEM. *Drug Court and Recovery Support Services: Washington Court and Recovery Enhancement System Outcome Evaluation*. Olympia, WA: Department of Social and Health Services Research and Data Analysis; 2014. 4.91.

[xx] Lipsky S, Krupski T, Roy-Byrne P. *Clients with Co-occurring Disorders have Poorer Chemical Dependency Outcomes.* Seattle, WA: University of Washington, Center for Healthcare Improvement for Addictions, Mental Illness, and Medically Vulnerable Populations (CHAMMP); 2009.

[xxi] Lucenko BA, Mancuso D, Estee S. *Co-occurring disorders among DSHS clients: A report to the Legislature.* Olympia, WA: Department of Social and Health Services Research and Data Analysis; 2008. 3.32.

[xxii] Wickizer TM, Mancuso D, Campbell K, Lucenko B. Evaluation of the Washington State Access to Recovery project: effects on Medicaid costs for working age disabled clients. *J Subst Abuse Treat.* Oct 2009;37(3):240-246.

[xxiii] Wickizer TM, Krupski A, Stark KD, Mancuso D, Campbell K. The effect of substance abuse treatment on Medicaid expenditures among general assistance welfare clients in Washington State. *Milbank Q.* 2006;84(3):555-576.

[xxiv] Mancuso D, Nordlund D, Felver BEM. *Arrests among working-age disabled adults: The role of mental illness and substance abuse.* Olympia, WA: Department of Social and Health Services Research and Data Analysis; 2007. 11.132.

[xxv] Mancuso D, Felver BEM. *Chemical dependency treatment, public safety: Implications for arrest rates, victims and community protection.* Olympia, WA: Department of Social and Health Services Research and Data Analysis; 2009. 11.140.

[xxvi] Estee S, Wickizer T, He L, Shah MF, Mancuso D. Evaluation of the Washington state screening, brief intervention, and referral to treatment project: cost outcomes for Medicaid patients screened in hospital emergency departments. *Med Care.* Jan 2010;48(1):18-24.

[xxvii] Meyer BD. *Natural and quasi-experiments in economics. Journal of Business and Economic Statistics, 13(2), 151−161.* 1995.

[xxviii] Pringle JL et al. The role of wrap around services in retention and outcome in substance abuse treatment: Findings from the Wrap Around Services Impact Study. *Addictive Disorders & Their Treatment*. 2002; 1(4):109-118.

[xxix] *Experimental and quasi-experimental designs for generalized causal inference. Boston: Houghton Mifflin.* 2002.

[xxx] Lucenko, B, Sharkova, I, Mancuso, D, and BE Felver. 2012. Adverse childhood experiences associated with behavioral health problems in adolescents. Olympia, WA, Department of Social and Health Services Research and Data Analysis.