

# **DIVISION OF BEHAVIORAL HEALTH AND RECOVERY**

## **FFY2019 UNIFIED BLOCK GRANT**

### **ASSESS THE STRENGTH AND NEEDS OF THE BEHAVIORAL HEALTH SYSTEM**

The Health Care Authority (HCA) is the Medicaid State agency that purchases health care for more than two million Washington residents through the Apple Health (Medicaid program) program and the Public Employees Benefits Board (PEBB) Program. In addition to these services, there are other initiatives to help ensure better health, better care, and lower costs. HCA previously only provided mental health services to clients with mental needs that do not meet the access to care standards. With the integration of substance abuse and mental health services, HCA now serves individuals with substance use disorders and individuals suffering higher acuity mental health disorders. This population was previously served by the Department of Social and Health Services (DSHS). As the largest health care purchaser in the state, HCA leads the effort to transform health care, helping ensure Washington residents have access to better health and better at lower costs.

During the 2018 Legislative Session, 2<sup>nd</sup> Engrossed Substitute House Bill 1388 passed the Legislature designating the Health Care Authority as the Single State Agency (SSA) for substance abuse and community mental health treatment services.

The DSHS will continue to operate the two state psychiatric hospitals that deliver inpatient psychiatric care to adults who have been committed through the civil or criminal court system for treatment and/or competency restoration services. DSHS will also continue to operate the Child Study and Treatment Center that provides high-quality inpatient psychiatric care and education to children ages 5 to 18 who cannot be served in less restrictive settings in the community due to their complex needs. The two state hospitals and the Child Study and Treatment Center have a combined inpatient capacity to serve 1,200 patients. In addition to providing inpatient services, the hospitals also provide outpatient forensic services to individuals who are waiting for an evaluation or for whom the courts have ordered an out-of-custody competency evaluation.

The Division of Behavioral Health and Recovery (DBHR) core services focus on:

- Individual Support – Providing support to clients who face challenges related to mental illness or substance use disorder and pathological/problem gambling, including the prevention of substance use disorder and mental health promotion.
- Health Care Quality and Costs – Designing and implementing integrated care systems in conjunction with other Divisions in the Health Care Authority and coordinates care with the Department of Social and Health Services to improve client health outcomes and contain health care costs.

Prior to the merger with HCA, DBHR was in charge of all of the administrative duties to support the division. Since the merger, HCA financial, legal and information technology administrations now support many of the administrative functions for the division.

DBHR provides a broad range of community based mental health, substance use disorder, and pathological and problem gambling services using multiple funding sources to meet the broad behavioral health needs for the citizens of our state. In addition, DBHR sponsors recovery supports and the development of system of care networks. Some of the key services DBHR provides are:

- Substance Use Disorder Prevention
- Intervention
- Outpatient substance use disorder and mental health services

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- Inpatient/residential substance use disorder and mental health services
- Substance use disorder prevention services
- Mental health promotion (funded with GF-State)
- Recovery support services
- Pathological and problem gambling services

DBHR manages the majority of public behavioral health services in Washington State. This includes program policy and planning, program implementation and oversight. In addition to these programs, DBHR contracts with the Division of Research and Data Analysis (RDA), within DSHS, to conduct comprehensive research and outcome studies.

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

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

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

- Building on a continuum of services including prevention, intervention, treatment, and recovery support, which incorporate evidence-based programs and practices whenever possible.
- Implementation of a fee-for-service program for American Indian (AI)/Alaskan Natives (AN) for substance use disorder and mental health treatment services.
- Develop cross agency strategies for opiate substitution treatment by securing several federal grants to address the opioid crisis.
- Develop a plan, process, and structure that supports treatment and recovery for individuals who experience a substance use and mental health disorder. Individuals who experience a co-occurring disorder (COD) have one or more substance use related disorders as well as one or more mental health related disorders.
- Implementation of Secure Withdrawal Management and Stabilization Facilities.
- Expanding to full integration with primary care by 2020 with early and mid-adopter regions during the time until full implementation.

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DBHR provides prevention, intervention, inpatient treatment, outpatient treatment, and recovery support to people who are at risk for addiction or diagnosed with mental illness. In calendar year 2017:

- 179,726 clients participated in mental health treatment (35,851 received crisis services).
- 64,944 clients participated in substance use disorder treatment.
- 17,801 clients received direct services with community strategies reaching over 100,000 clients with substance use disorder prevention activities.
- 418 clients participated in pathological and problem gambling treatment.

The total current 2017-19 biennial budget for Mental Health community services is \$1,943,771,000 of this amount:

- GF-State \$852,887,000
- Federal Discretionary Funds \$31,759,000
- Local \$18,115,000
- Medicaid \$1,032,456,000
- Designated Marijuana Account \$7,368,000
- Pension Stabilization Account \$1,186,000

Currently, \$1.6 million of the MHBG funds are set aside for First Episode Psychosis (FEP) and \$1.0 million of the MHBG funds are used for services for children with Serious Emotional Disorders (SED).

The total current 2017-19 biennial budget for Alcohol and Substance Abuse is \$908,703,000 of this amount:

- GF-State \$174,436,000
- Federal Discretionary Funds \$126,622,000
- Local \$19,430,000
- Medicaid \$520,627,000
- Criminal Justice Treatment Account \$12,978,000
- Problem Gambling \$1,478,000
- Designated Marijuana Account \$49,604,000
- Pension Stabilization Account \$49,604,000

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

- Comprehensive community-based services for adults who have serious mental illness, older adults with serious mental illness, children with SED and their families, as well as individuals who have experienced a first episode of psychosis.

Services for persons with or at risk of substance use and/or mental health disorders with the primary focus on:

- Pregnant and Parenting women
- Persons who Inject Drugs
- Persons at risk for Tuberculosis

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

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

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

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

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

### **CONTRACTING OF THE PUBLIC BEHAVIORAL HEALTH SYSTEM**

The Washington Legislature (RCW 71.24.850) set forth two pathways for the integration of behavioral health and physical health care by January 1, 2020:

- 1) Behavioral Health Organizations (BHOs) as Prepaid Inpatient Health Plans with a purchasing model in which care for behavioral health (mental health and substance use) disorders for Medicaid beneficiaries is delivered through contracts between DSHS and the BHOs.
- 2) Fully Integrated Managed Care (FIMC) Regional Service Areas with a purchasing model through contracts between the HCA and Managed Care Organizations (MCO) for both medical and behavioral health (mental health and substance use disorder services).

#### **Behavioral Health Organizations (BHO)**

As required by the Washington State Legislature, the substance use disorder (SUD) and mental health (MH) services were integrated into a behavioral health managed care benefit on April 1, 2016. This

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required the formation of regional BHOs that have at-risk contracts to deliver both substance use disorder and mental health services also known as Prepaid Inpatient Health Plans (PIHPs). The BHOs contract for direct services with local providers to provide an array of behavioral health services based on medical necessity, oversee the distribution of funds under the state managed care plan, provide utilization management and other administrative functions, and develop quality improvement and enrollee protections for all Medicaid clients enrolled in the BHO system. The capitated managed care behavioral health system gives the BHOs the ability to design an integrated system of mental health and substance use disorder care and subcontract with networks of community behavioral health agencies capable of providing high quality service delivery, which are age appropriate and culturally competent.

In addition to the managed care program for MH and SUD services, the BHOs and the Administrative Services Organizations (ASO) hold the State-only and federal block grant contracts to serve those individuals that are not covered by Medicaid or to fund services that are not covered by Medicaid.

The BHOs and ASOs also collaborate with Washington's Apple Health Medicaid-funded managed care program to ensure coordinated care for enrollees. The Apple Health managed care program provides a full array of medical services as well as mental health services for those who do not need higher levels of care for mental health services.

#### **Fully Integrated Manage Care (FIMC)**

As part of the same Legislation that required the integration of substance use disorder and mental health services, the state was required to move toward full integration of all physical and behavioral health under integrated managed care contracts by January 1, 2020.

In order to start the process of moving towards all regions being integrated for the full continuum of care, two regions of the state fully integrated behavioral and physical health care purchasing. Two Managed Care organizations were awarded contracts for the Medicaid program and the ASO was awarded a contract to manage non-Medicaid state funds as well as the federal block grant programs.

The expectation is that over the next two years other regions will be added to the fully integrated program. As of January 1, 2019, five more regions will be integrating and the remaining three regions will be integrate by January 1, 2020.

#### **Fee-for-Service Program (FFS)**

In response to the concerns expressed by the Washington State Tribes and Urban Indian Health Organizations; the Centers for Medicaid and Medicare Services (CMS) and the State of Washington agreed that persons who self-identify as American Indian/Alaska Native (AI/AN) and are a Medicaid enrollee are exempt from the integration of behavioral health treatment (substance use disorder and specialized mental health) services provided by managed care programs. All AI/AN Medicaid clients receiving behavioral health services through the BHO were transitioned to the FFS program. In the FFS program, Medicaid services are not purchased, provided or authorized by Behavioral Health Organizations (BHO) or Managed Care Organizations (MCO). Services provided are based on medical necessity and determined by the provider agency. On April 1, 2016, AI/AN Medicaid enrollees received their SUD treatment services without having to receive authorization from a BHO.

Effective July 1, 2017, clients have the freedom to choose any behavioral health provider who is participating in the FFS program and currently accepting patients. They are not limited be county or

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geographic regions. BHOs and MCOs do not have clinical or financial responsibility. The services provided under the AI/AN FFS program are the same Medicaid State Plan services provided through the managed care programs.

Any licensed and certified provider is eligible to register to be a FFS Provider. FFS Providers do not need to be a BHO provider. There are currently 265 non-tribal provider, statewide, participating as FFS providers.

### **Civil Commitment-Long Term Inpatient Beds**

The 2018 Legislature has directed the department to contract directly with licensed and certified community hospitals or freestanding evaluation and treatment centers, rather than through behavioral health organization, to provide up to forty-eight long term inpatient care beds as defined in RCW 71.24.025. Six agencies have started the contracting process that will allow them to hold beds for clients who have been mandated by court process for civil commitment stay that is 90-180 days. (Reference [Washington State Budget Proviso Language from Section 204 Q of the enacted 2018 Budget, Chapters 246-320 and 246-322 WAC, and RCW 71.05](#)).

### **Tribal Agreements and Contracts with Tribes**

DBHR continues to provide funding opportunities for tribes to support substance use disorder prevention and treatment programs and to enhance mental health services administered by the tribes.

Specifically, the Consolidated Contract between DSHS and each individual Tribe is for services provided in a tribal behavioral health program. This contract includes two funding sources with separate reporting structures. The largest portion of the contract is funded with the SABG, and the Tribes receive two additional mini-grants funded through the State Legislature (Mental Health Promotion Projects and the Dedicated Marijuana Funds Account). These contracts provide financial support for the 29 Federally Recognized Tribes for culturally based treatment services and/or prevention activities. Tribal programs provide services mainly to the tribal populations, but the Tribes can also serve non-tribal members. It is important to note that Tribes are not required to participate in the Consolidated Contract.

Since July 1997, DBHR has been able to provide funds to the Federally Recognized Tribes in Washington State to support the delivery of outpatient treatment services by tribal facilities and community-based prevention activities to tribal members. Each tribe receives a base of \$57,499 per biennium, the remaining \$1.4 million in funding is allocated to the tribes based on a methodology of 30 percent on population and 70 percent is distributed evenly between the tribes.

Not only can Tribes contract with DBHR, but Tribes also have the opportunity and option to contract with the BHOs. Tribes have the opportunity to contract with any BHO to provide outpatient and/or residential SUD and MH services to individuals in their communities. These contracting opportunities are available to the Urban Indian Health Programs as well. These contracts are negotiated between the BHO and the Tribe or Urban Indian Health Program.

Tribal substance use disorder prevention and mental health promotion programs are specific to each Tribe's local needs, culture, and traditions. Tribes select evidence-based programs or develop tribal prevention programs that best serve their members and surrounding community members. Tribes develop an annual prevention program plan with the assistance of DSHS's Office of Indian Policy (OIP) and DBHR.

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Separate from block grant funding, the Tribes receive Medicaid funding based on the Federal Memorandum of Agreement (MOA), and the rate is based on the Indian Health Services (IHS) Encounter Rate. Under the terms of the federal MOA, tribally owned clinics authorized through IHS who serve Tribal members receive reimbursement at 100 percent of the federal encounter rate for substance use disorder treatment services. In addition, authorized Tribes can serve non-tribal members and receive 50 percent of the encounter rate for substance use disorder treatment services. In coordination with HCA, DBHR offers technical assistance, training, and consultation to tribal Federally Qualified Health Centers (FQHC) and Tribal 638 mental health programs on billing procedures and Medicaid regulations.

In April 2016, DBHR, HCA, Indian Health Services (IHS) Direct, Tribal 638, and Urban Indian Health Programs (I/T/U) system of care worked together to implement the fee-for-service system for SUD and MH treatment services for AI/AN individuals covered by Medicaid. Medicaid funding pays for outpatient and residential SUD and MH services for these clients who receive these services from a fee-for-service (FFS) provider. For those AI/AN clients who are non-Medicaid, they are able to receive services from their tribal behavioral health provider and/or from a non-tribal provider within the BHO system of providers. BHOs also use block grant funding to pay for the SUD and MH services for these non-Medicaid clients.

### **Primary Prevention Services**

DBHR prioritizes funding for research based strategies to prevent substance use, while at the same time recognizing the importance of local innovation to develop programs for specific populations and emerging problems.

Funding is primarily disseminated via:

- County contracts.
- Community-based organization contracts.
- Inter-local contracts.
- Consolidated Intergovernmental Agreements (IGA) with Washington State Federally Recognized tribes through the Office of Indian Policy (OIP).
- Personal service agreements for services such as workforce development training and capacity building.

Most services provided are structured evidence-based drug and alcohol prevention curriculum for youth and parenting classes for adults. Information dissemination efforts and alternative drug-free activities are permitted as part of comprehensive program plans. Services also include community organizing efforts and environmental strategies that impact policy, community norms, access and availability of substances and enforcement of policies directed at substance use prevention. DBHR leads and engages in several state-wide collaborative efforts that focus on workforce development; planning and data collection for youth and young adults; mental health promotion; and prevention of underage drinking, youth marijuana use, prescription and opioid misuse and abuse.

Washington State's Community Prevention and Wellness Initiative (CPWI) is a strategic, data-informed, community coalition model aimed at bringing together key local stakeholders in high-need communities to provide infrastructure and support to successfully coordinate, assess, plan, implement and evaluate youth substance use prevention services needed in their community. The CPWI is modeled after several

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evidence- and research-based coalition models that have been shown to reduce community-level youth substance use and misuse and related risk and protective factors including SAMHSA's Strategic Prevention Framework.

DBHR contracts with the Office of Superintendent of Public Instruction (OSPI) for the placement of Prevention/Intervention (P/I) specialists in schools to provide universal, selective, and indicated prevention and intervention services. P/I specialists assist students to overcome problems of substance misuse and strive to prevent the misuse of, and addiction to, alcohol and other drugs, including nicotine. The P/I specialists also practice problem identification and referral strategies through referrals to mental health and substance use disorder treatment providers and support students in their transition back to school after they receive treatment.

Tribes have the discretion to use currently allocated SABG prevention funds to support Prevention Intervention Specialist (PIS). Tribes that have a PIS in place are implementing Project SUCCESS. Project SUCCESS is a model for prevention intervention (PI) used statewide in Washington State. Funds support PI staff time in a school to provide both prevention and intervention services. A tribal PIS presented about Project SUCCESS at DBHRs Tribal Prevention Learning Community meeting. More detail is available in the [Project SUCCESS link](#).

Washington State's community-based organizations (CBOs) grantees serve high-need communities to provide quality and culturally competent replications of evidence-based, research-based, and promising substance use prevention programs. This statewide process provides services using the list of approved prevention programs within defined percentages. Organizations are encouraged to partner with Community Prevention and Wellness Initiative (CPWI) community coalitions or other existing community coalitions when possible, and follow the same reporting requirements as current prevention service providers.

### **ADULT BEHAVIORAL HEALTH SYSTEM**

#### ***Mental Health***

The BHOs and the FIMCs, through contracts with community mental health agencies, provide a complete array of services to adults with serious mental illness (SMI) who meet the Access to Care standards (diagnosis and level of functional impairment) and standardized medical necessity criteria. The list of possible services may include brief intervention, crisis services, family treatment, freestanding evaluation and treatment, individual and group treatment, high intensity treatment, medication management and monitoring, residential treatment, and stabilization services.

Each BHO and FIMC contracts with provider groups and community mental health agencies. Each BHO and FIMC network serves all Medicaid enrollees within its geographical area. Crisis services are available to all residents of the state, without regard to funding or Medicaid eligibility.

The BHOs and ASOs administer the Involuntary Treatment Act (ITA) and the crisis response system for all people in their service area, regardless of income or eligibility. In most communities, crisis and involuntary services are highly integrated. Crisis services include a 24-hour crisis line and in-person evaluations for those presenting with mental health crises. Crises are to be resolved in the least restrictive manner and should include family and significant others as appropriate and at the request of



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the consumer. ITA services include in-person investigation of the need for involuntary inpatient care. A person must meet legal criteria and refused or failed to accept less restrictive alternatives to be involuntarily detained.

Voluntary and involuntary community inpatient services for adults are provided in community hospital psychiatric units and in freestanding non-hospital evaluation and treatment facilities (E&Ts) authorized by the BHOs and ASOs. Some inpatient resources are certified for short-term (up to 17 days) ITA services.

In addition to community based services, BHA also operates two state psychiatric hospitals who serve individuals who are civilly committed under RCW 71.05 for court ordered 90- or 180-day civil commitments. The state hospitals provide evidence-based professional psychiatric, medical, habilitative, and transition services within a Recovery of System of Care model and coordinates with the BHOs to transition clients back into the community. The state psychiatric hospitals also serve individuals committed under RCW 10.77 who are court-ordered criminal defendants needing competency and restoration services. Jail and community-based competency evaluations are also offered locally.

### **Substance Use Disorder Treatment**

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

Each BHO contracts with provider groups and community substance use disorder agencies. Each BHO and FIMC serves all Medicaid enrollees within its geographical area except for AI/AN who have opted out of receiving SUD services through the BHOs but instead have opted to receive services through the fee-for-service delivery system.

Intensive residential and outpatient treatment for substance use disorder includes counseling services and education. Some patients receive only outpatient or intensive outpatient treatment. Other patients transfer to outpatient treatment after completing intensive residential services. Relapse prevention strategies remain a primary focus of counseling. There are currently three types of residential substance use disorder treatment settings for adults in the state:

- Intensive inpatient treatment provides a concentrated program of individual and group counseling, education, and activities for people who are addicted to substances and their families. There are currently 69 intensive inpatient residential providers with a total capacity of 2,146 beds. The BHOs may subcontract for intensive inpatient services. Each patient participating in this level of substance use disorder treatment receives a minimum of 20 hours of treatment services each week.
- Long-term residential treatment provides treatment for the chronically impaired adult with impaired self-maintenance capabilities. There are currently seven adult long-term residential providers with a total capacity of 135 beds. Each patient participating in this level of substance use disorder treatment receives a minimum of four hours of treatment per week.

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- Recovery Houses provide personal care and treatment, with social, vocational, and recreational activities to aid with patient adjustment to abstinence, as well as job training, employment, or other community activities. There are currently five adult recovery house providers with a capacity of 58 beds statewide. Each patient participating in this level of substance use disorder treatment receives a minimum of five hours of treatment services per week.

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

- Sub-acute Detox are clinically managed residential facilities that have limited medical coverage. Staff and counselors monitor patients and any treatment medications are self-administered.
- Acute Detox are medically monitored inpatient programs that have medical coverage by nurses and physicians who are on-call 24/7 for consultation. They have “standing orders” and available medications to help with withdrawal symptoms. They are not hospitals but have referral relationships with them.
- Acute Hospital Detox is medically managed intensive inpatient that have medical coverage by registered nurses and nurses with doctors available 24/7. There is full access to medical acute care including the intensive care unit if needed. Doctors, nurses, and counselors work as a part of an interdisciplinary team who medically manage the care of the patient. This level of care is considered hospital care and is not part of the behavioral health benefits provided through the BHOs or MCOs.
- Secure Withdrawal Management and Stabilization Facilities are licensed as a secure residential treatment facility to provide withdrawal management and stabilization treatment under the supervision of a physician. These services are provided for up to seventeen days for individuals who are detained under the civil involuntary treatment law and present a likelihood of serious harm to themselves or others or are gravely disabled due to a substance use disorder.

### **CHILDREN AND YOUTH BEHAVIORAL HEALTH SYSTEM**

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

- Legislative direction for the creation of Behavioral Health Organizations which began in April 2016. Behavioral Health Organizations took lead in integrating Substance Use Disorder services into managed care with mental health services. This process is the first step to full purchasing integration with physical and behavioral health services.
- Implementation of Wraparound with Intensive Services (WISe) emphasizes a wraparound approach to both high-level and other level need youth cases, adopting the Child and Adolescent Needs and Strengths (CANS) assessment tool to evaluate needs and strengths in multiple domains. Access to Care Standards highlights the need to evaluate functional need in all domains.
- Washington State’s First Episode Psychosis Initiative, placing emphasis on early intervention services for individuals experiencing early onset symptoms of schizophrenia.
- Family Peer Partner and Youth Peer Partner development in services and system development.

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- As a part of our Washington Administrative Code (WAC) 388-877-0620 Clinical – Individual Service Plan outlines components required for mental health and substance use disorder treatment; including, but not limited to:
  - Address age, gender, cultural, strengths and/or disability issues identified by the individual or, if applicable, the individual's parent(s) or legal representative.
  - Use a terminology that is understandable to the individual and the individual's family.
  - Demonstrate the individual's participation in the development of the plan.
  - Document participation of family or significant others, if participation is requested by the individual and is clinically appropriate.
  - Be strength-based.
  - Contain measurable goals or objectives, or both.

The state has established collaborations with other child and youth serving agencies in the state to address behavioral health needs as evidenced by the coordinated contracts with Children's Long Term Inpatient Program (CLIP) and Behavioral Health Organization regions. This effort has been strengthened by the System of Care Grant and T.R. Settlement driven Children's Behavioral Health Governance Structure including the Children's Behavioral Health Executive Leadership Team, the Statewide FYSPT, and ten Regional FYSPTs. The Statewide FYSPT has a tribal representative and representatives from these six youth-serving state partners: Rehabilitation Administration-Juvenile Rehabilitation (RA), Department of Health (DOH), Children's Administration (CA), Health Care Authority (HCA), Office of Superintendent of Public Instruction (OSPI), and Developmental Disabilities Administration (DDA).

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

Contractors are required to implement at least 15 percent Evidence/Research-Based Programs and/or Practices (EBPPs) into the Behavioral Health Organization contracts for children/youth. The required percentage increases yearly with 2017 contractual requirements ending at 30 percent. The intention is by the end of 2019, the percentage of EBPP services for children and youth will be no lower than 45 percent per region.

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

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

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

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### **Mental Health Services**

A program agreement was established to coordinate activities that promote cross-systems collaboration between local public mental health providers and local education agencies (LEAs) to provide services and programs for students who are eligible for special education services under the Individuals with Disabilities Education Act (IDEA) and who are eligible for services through the DBHR.

### **Treatment**

In 2015, two counties (one rural, one urban) piloted a project to address co-occurring disorders for students in a school-based setting. This project was in concert with the Office of Public School Instruction and focused on building capacity for the screening, assessment, referral, case management, and treatment to students with co-occurring disorders. This project enlisted a mental health professional, under the direct clinical supervision of a dually licensed chemical dependency and mental health professional, to serve a minimum of 50 youth with co-occurring needs. The direct services delivered are based on best practices identified by the University of Washington Evidence-Based Practice Institute.

### **AN OVERVIEW OF THE CONTINUUM OF CARE**

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

### **Prevention/Mental Health Promotion**

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

### **Intervention**

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

### **Mental Health Treatment**

DBHR funds the BHO and FIMC to provide an integrated public mental health treatment system for persons experiencing mental illness who are enrolled in Medicaid and meet the statutory need definitions for those experiencing a mental health crisis and for those who are deemed a danger to themselves or others due to a mental disorder. Medical necessity and Access to Care Standards (ACS), established by the department and approved by the Centers for Medicare and Medicaid Services (CMS), govern access to services for mental health. In general, to meet the ACS criteria, a person must have a covered diagnosis, significant functional impairment, and the requested service is reasonably expected

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to improve, stabilize, or prevent deterioration of functioning resulting from the presence of a mental illness.

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

#### **Crisis Services**

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

DBHR awarded the Seattle Crisis Clinic a performance-based contract to operate a new behavioral health recovery help-line. The Washington Recovery Help-Line offers 24-hour emotional support and referrals to local treatment services for residents with substance use, problem gambling, and mental health disorders. The Crisis Clinic also operates Teen Link, a teen-answered help line, each evening.

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

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

If an AI/AN who is served by a tribal behavioral health provider is in crisis, DBHR requires that the BHOs coordinate with the tribal behavioral health provider to provide continuing services during and after the crisis. This is contingent upon the AI/AN client signing a release of information.

#### **Substance Use Disorder Treatment**

Substance use disorder assessments use the American Society of Addiction Medicine (ASAM). This assessment determines consumer need and the corresponding level of care or modality of service that meets that need. Outpatient or residential treatment can be the first level of care, depending on patient need per ASAM. Certified treatment agencies provide the outpatient substance use disorder services in local communities. If the consumer needs residential substance use disorder treatment, referral is made to the statewide residential treatment system.

DBHR is a recipient of the State Adolescent Treatment Enhancement and Dissemination (SAT-ED) and the State Youth Treatment – Implementation (SYT-I) grants. These grants provide the opportunity for

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enhanced treatment and recovery services for youth (ages 12 to 18) who have a substance use disorder diagnosis and youth who have a co-occurring substance use disorder and mental health disorder diagnosis (COD).

### **Pregnant Women and Women with Dependent Children**

The Pregnant and Parenting Housing Support Services provides housing support services for woman who are pregnant, postpartum, or parenting women with children in drug and alcohol-free residences for up to 18 months. A care plan is developed for clients that identifies community supports to maximize recovery. Case Managers coordinate outpatient substance use disorder treatment and facilitate prenatal and post-natal medical care, financial assistance, social services, vocational services, childcare needs, and permanent housing.

Therapeutic Intervention for Children services provides for children of parents receiving residential substance use disorder services. Services are for care, protection, and treatment of children who are at risk of abuse, neglect and eventual substance abuse. Services includes: developmental assessments, play therapy, behavioral modification, individual counseling, self-esteem and family intervention to modify parenting behavioral and/or the child's environment to eliminate/prevent the child's dysfunctional behavior. Childcare is provided at nine Pregnant and Parenting Women (PPW) residential substance use disorder treatment settings when children accompany their mother to treatment.

In SFY 2018, the Legislature provided DBHR with additional funding in a supplemental budget, this funding was used to expand the number of client slots at existing PCAP sites. The Parent Child Assistance Program (PCAP) provides advocacy services to high-risk, substance-abusing pregnant and parenting women and their young children. PCAP is supported with State and Medicaid funding. Services include referral, support and advocacy for substance abuse treatment and continuing care services. PCAP assists participants in accessing local resources such as family planning, safe housing, health care, domestic violence services, parent skills training, childcare, transportation, and legal services. This program supports linkages to health care and appropriate therapeutic interventions for children. PCAP is carved out managed care and is currently available in 15 counties: King, Pierce, Yakima, Spokane, Cowlitz, Chelan, Skagit, Clallam, Kitsap, Clark, Grays Harbor/Pacific, Thurston/Mason/Lewis, Whatcom, Snohomish, and Benton/Franklin. In early 2000, Spokane Tribe was deemed a PCAP agency. Unfortunately, the tribe was not able to continue this program. Even with the loss of the Spokane Tribe PCAP tribes has still be able to be linked with existing PCAPs.

The Washington State Fetal Alcohol Syndrome Diagnostic and Prevention Network (WA FASDPN) includes two community-based interdisciplinary fetal alcohol spectrum disorder (FASD) diagnostic clinics in Yakima and Everett, linked by the core clinical/research/training program at the University of Washington. The mission of the WA FASDPN is FASD prevention through screening, diagnosis, intervention, research, and training. The WA FASDPN:

- Provides 100 percent of the state's interdisciplinary FASD diagnostic and treatment referral services to individuals of all ages with fetal alcohol exposure.
- Provides FAS screening and surveillance for high-risk populations.
- Identifies and refers high-risk women to intervention programs.
- Develops FASD screening, diagnostic, and intervention tools through its translational research program.
- Provides FASD training to community professionals.

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- Is recognized as a national/international model for FASD diagnosis and prevention. This program has been replicated worldwide.

### **Pathological and Problem Gambling**

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

### **Office of Consumer Partnership**

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

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

## **WORKFORCE DEVELOPMENT**

### **Tribal Behavioral Health Conference**

Washington maintains a Government to Government relationship with Federally Recognized Tribes. As the state transitions into managed care, and the tribal behavioral health system remains a fee-for-service system, ongoing communication collaboration, and education for tribal and non-tribal providers is essential. In light of this, the American Indian Health Commission sent a request on March 1, 2017, to DSHS and the Health Care Authority for funding to sponsor a tribal behavioral health conference to help educate those involved in the upcoming fee-for-service transition for mental health services. The purpose of the Tribal Behavioral Health Conference is to provide a forum for health professionals from Tribes, Urban Indian Health Organizations, all Indian Health Care Providers, Behavioral Health Organizations, Community Mental Health Agencies, Accountable Communities of Health, and others to share best practices for the delivery of mental health and substance use disorder treatment services for American Indians (AI) and Alaska Natives (AN) in Washington State, as well as providing a forum to discuss the legislatively-driven directive to integrate behavioral health and physical health services by 2020. Topic areas included:

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- July 1, 2017 implementation of Medicaid mental health fee for service benefits
- Clinical models
- Operational approaches
- Financial strategies

DBHR provides funding for five annual statewide conferences and trainings:

### **Co-Occurring Disorder Conference**

The annual Washington State Co-Occurring Disorder Conference (COD) and Treatment Conference will be held in Yakima at the Convention Center on October 15 and 16, 2018. Ethics and Suicide Prevention will be provided on October 14, 2018. Post conference workshops on Motivational Interviewing and Trauma Informed Care will be held on Wednesday, October 17th. The conference provides attendees (including consumer and family) with information regarding current legislation related to mental health care and services, current resources, and treatment methodologies.

This year, the COD conference plenary sessions focus on Delectable Behavioral Therapy, Recovery, Eating Disorders, Trauma, the Effects of Cannabis and Cannabinoids, Medication Assisted Therapies, and Developmental Disabilities. In addition, the plenary focus areas will also have workshops addressing Motivational Interviewing, Trauma, Recovery, and Medication Assisted Therapies. The conference also provides opportunities for participants to network with other service providers, state representatives, other families, and individuals with COD.

### **Saying it Out Loud Conference**

The Saying it Out Loud (SIOL) Conference is planned in partnership with the Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) communities and other Administrations (Behavioral Health Administration, Rehabilitation Administration, and the Aging and Long-Term Support Administration). This conference brings together professionals from the diverse fields of social work, mental health, substance use disorder treatment, and substance use prevention to focus on the impacts of substance use disorder and mental health on LGBTQ individuals and communities. The Dept. of Social and Health Services (DSHS) has had a long-standing record of supporting and partnering with the LGBTQ community.

This year's conference was held at the Greater Tacoma Convention and Trade Center on Monday April 23, 2018. There were approximately 450 attendees from around the state of Washington. The keynote, Talcott Broadhead, non-binary author, artist, parent, and radical social worker spoke to finding ones identity beyond the binary of male and female, embracing what it means to be gender non-conforming. To share compassion and respect, not allowing those who find discomfort in one's comfort keep themselves from being true to who they are. Talcott has provided years of Transgender Liberation, and anti-biased focused advocacy, therapy, training and education to a variety of clientele and audiences.

Workshops were offered to increase and encourage awareness, communication, and improve service delivery for LGBTQ individuals of all ages. Presenters shared how to improve coordination of care across systems and increase services and supports. We offered two population focused tracks; youth and elder, where topics focused on understanding transgender and gender diverse children and teens, clinical considerations, LGBTQ aging challenges and veteran's benefits. Additional workshop included Uncovering Unconscious Bias, LGBTQ+ 101, Telling Our Stories – For Us, By Us, Improving Systems of



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Care for LGBTQ+ youth, HIV Care Continuum, LGBTQ Breast Health Toolkit Training, Unique needs of LGBTQ Immigrants, Refugees, and Undocumented Individuals.

Each year, the latest research and best practices are shared with conference attendees, having one mission in mind, and that is to improve the quality of care, health and wellbeing of LGBTQ individuals.

#### **Behavioral Health Conference**

The Behavioral Health Conference is a three-day statewide behavioral health care conference presented by the Washington Council for Behavioral Health (WCBH) and supported by the federal block. This year's conference theme is "Resilience, Innovation, Health" was held June 20-22, 2018 in Vancouver Washington.

The conference audience included mental health professionals in areas of aging, corrections, developmental disabilities, children's services, primary health, substance use disorder and other specialties including consumers and consumer advocates, administrators, staff of treatment agencies and other stakeholders. Over 350 consumers and consumer advocates, including Behavioral Health Advisory Committee members, were in attendance.

#### **Prevention Summit and Youth Forum**

The goal of the Washington State Prevention Summit is to provide an enriching and culturally competent training and networking opportunity for youth, volunteers, and professionals working toward the prevention of substance abuse, violence and other destructive behaviors. The two-day conference event includes high-quality workshops, forums, and hands-on learning opportunities meet a variety of needs, including professional development for prevention providers. The Prevention Summit also features a track tailored to youth (ages 12-18).

#### **Washington State Spring Youth Forum**

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

#### **Peer Support Training**

Washington State's Peer Support Program began in 2005 training mental health individuals with lived experience to become Certified Peer Counselors. Peer support is now provided in every region of the state.

Peer Services is expanding through programs such as: Peer Bridger, HARPS, Supported Housing, Supported Employments and in Tribal Communities. In addition, to meet workforce needs, additional focus is on continuing education and assisting agencies to incorporate peers support services. DBHR also concentrated efforts to maximize the training attendance. DBHR has continued to reach out to Tribal communities to provide peer certification. Tribal peers have been included in the CPC trainings and DBHR has held trainings specifically to meet the needs of growing tribal peer support programs.

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In SFY 2017, our program managed 18 Certified Peer Counselor training and testing events that trained 360 peers. SFY 2018 produced 21 total training and testing events, training over 475 peers.

Tribes have been working on the development of a CHAP Board and behavioral health aides that are similar to peer supports services as described. North Sound BHO has a contract with the Northwest Portland Area Indian Health Board to support that development. Tribes are interested in discussing, with DBHR, the opportunity to consider behavioral health aides in the same class as Peer SUD Counselors for certification and funding purposes.

In addition to certification training, peer counselor continuing education trainings include Supervision, Ethics, Trauma Informed Peer Support, Suicide Prevention, and Wellness Recovery Action Plan. DBHR also expanded technical assistance to agencies and organizations that need support in operationalizing peer support (OPS). DBHR has provided over 100 hours of technical assistance in peer support and recovery oriented practices.

DBHR is pursuing peer services for the Substance Use treatment population, and has convened a SUD Peer Support workgroup in response to the Legislature who directed DBHR to initiate SUD peer certification program. Through SAMSHA technical assistance and stakeholder input, DBHR has an initial plan and has begun action steps to prepare for this service. Action steps include: Convening a statewide stakeholder group and piloting two (2) SUD Peer trainings, which included curriculum updates. One of the strategies is to capitalize on the Recovery Coach trainings provided to peers by our STR project. The Peer Training program is creating a “bridge training” for recovery coaches that may want to work providing this new peer service.

This next year DBHR will need to increase the capacity for trainings. In addition to SUD Peer Services, DBHR will also be training Peer Specialist to meet the demands of the workforce for the 1115 demonstration waiver. It is estimated that approximately 200 new positions, across the state, in Supported Employment and Supportive Housing will be filled with Peers.

### **INNOVATIVE BEHAVIORAL HEALTH STRATEGIES IN WASHINGTON STATE**

#### **Addressing the Opioid Crisis**

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

- The Washington State Project to Prevent Prescription Drug/Opioid Overdose (WA-PDO) is a collaborative five-year project between DBHR and the University of Washington Alcohol and Drug Abuse Institute (ADAI) with the purpose of preventing opioid overdose and deaths from opioid overdose, and building local infrastructure to plan, implement, evaluate, and fund overdose prevention efforts in the long-term.
- The Prescription Drug and Opioid Addiction Project (WA-MAT-PDOA) will expand access to integrated medication assisted treatment (MAT) with buprenorphine for individuals with an opioid addiction. A proven office-based opioid treatment (OBT) model is in both a large urban safety-net primary care clinic and two opioid treatment program sites who serve predominately rural populations. The WA-MAT-PDOA is a collaborative effort between state agencies,

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Harborview Medical Center, and Evergreen Treatment Services to address the rising rates of opioid-related problems in Washington.

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

### **Implementation of Secure Withdrawal Management and Stabilization (SWMS) Facilities**

In 2016, House Bill 1713 addressed the lack of bed capacity to fulfill Ricki's Law (SUD ITA) and made changes to the behavioral health system, to include: training for current designated mental health professionals (DMHPs); and, operationalizing nine (9) facilities by 2026 with the first by April 1, 2018. Currently there is one agency, American Behavioral Health Services that has two SWMS facilities operating: 24 beds in Spokane, and 21 in Chehalis. HCA/DBHR expects to have all nine facilities options available within the timelines established in HB 1713.

Staff at DBHR can provide technical assistance to Tribal programs and providers to develop Secure Detox facilities by submission of letter of interest.

Effective April 1, 2018, the bill amends RCW 71.05 and 71.34 to align the substance use involuntary treatment process with the existing mental health ITA process. DBHR will be combining the functions of the Designated Mental Health Professional and the Designated Chemical Dependency Specialist to Designated Crisis Responders who will be authorized to carry out the functions of RCW 71.05 and 71.34. In addition, the bill directs the department to create a sixteen-bed secure detoxification facility to be operational by April 1, 2018. It further directs the department to create one additional facility per year until there is a total of nine facilities statewide. These facilities will be licensed as a secure residential treatment facility certified by DBHR to provide withdrawal management and stabilization treatment, under the supervision of physician, for individuals detained under civil involuntary treatment law. These facilities will provide up to 17 days of withdrawal management and stabilizing care to individuals who present a likelihood of serious harm to themselves or others, or are gravely disabled due to a substance use disorder and require withdrawal management treatment. Individuals in need of substance use disorder treatment longer than seventeen days may receive outpatient or residential treatment voluntarily or on a less restrictive alternative.

On April 1, 2018, DBHR opened two adult Secure Withdrawal Management and Stabilization Facilities who provide withdrawal management services for up to seventeen days for individuals who present a likelihood of serious harm to themselves or others or are gravely disabled due to a substance abuse use disorder and require withdrawal management treatment services. The two facilities are geographically located to provide services on both sides of the state, 21 beds are located in Western Washington and

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24 beds are located in Eastern Washington. In addition to these two facilities, it is expected that there will be an additional 43 beds available by October 2018.

### **Co-Occurring Disorders**

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

The workgroup set a number of expectations for its work. The group will consider definitions associated with substance use related disorders, mental health disorders, co-occurring disorders, and programs. Key issues include integrated screening, assessment, and treatment planning. Individuals with COD are best served through an integrated screening, assessment, and treatment planning process that addresses both substance use and mental health disorders. Other issues will address appropriate staffing, protocols, methods, and processes for integrated screening, assessment, and treatment planning for persons with COD as well as systems issues and payment/financing.

The DBHR COD Workgroup will continue to meet during SFY18 and anticipates implementing a statewide COD program by July 1, 2018.

Late last year, the state implemented a pilot program in King County that is now providing co-occurring services for individuals who are experiencing SUD and MH disorders. This work led to a single set of rules with the Department of Health which became effective July 1, 2018.

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### **WASHINGTON STATE NEEDS ASSESSMENT**

As part of Washington's integration of behavioral and physical health services, the responsibilities of the Division of Behavioral and Recovery (DBHR) moved to the Health Care Authority (HCA) on July 1, 2018. House Bill 1388 passed the Legislature during the 2018 session and was signed into law by Governor Inslee. This new law moves mental health authority and substance use prevention and treatment services to HCA. These changes have moved substance use disorder treatment services from a fee-for-service program to a managed care model which required changes in how data is being collected. Washington continues to work through the data challenges and the need for data in the integrated regions. However, Washington continues to work with a contractor to better understand the challenges and work to resolve the problem by April 2020.

The Division continues to serve the American Indian (AI)/Alaska Native (AN) population, who continue to have the option of receiving mental health and substance use disorder treatment through the Medicaid managed care system or through a fee-for-service (FFS) delivery system. Data for the FFS program is collected in the BHDS via the Provider Entry Portal.

The BHDS system has modernized the flow of data, provided increased security, improved accountability, and increased transparency of information, which will assist in refined management decisions and policy development. This system has also strengthened the monitoring and quality of the service delivery system, enhanced outcome analysis for the entire organization, and will further align the organization to a managed care model while maintaining DBHR's ability to track priority outcomes, such as employment and housing for adults with serious mental illness (SMI) and children with serious emotional disorder (SED).

DBHR continues to have conversation with Tribal programs on the best way to collect data that will accurately reflect the needs among Tribes. Because of the lack of data there still continues to be a gap in meeting the needs of AI/AN communities.

At this time Tribal program are not required to enter data into the new data system. Beginning fall of 2018, DBHR, along with Tribes, will strategize on moving Tribal data to the new system. Until a final plan is established Tribes will continue to utilize the Treatment and Reporting Generation Tool (TARGET) to record treatment services.

Substance use disorder prevention and mental health promotion services are reported by prevention providers to DBHR via the Substance Use Disorder Prevention and Mental Health Promotion Online Reporting System (the Prevention MIS, or "Minerva"). Information on local prevention services are used by local providers and statewide by DBHR to document, track, monitor, and report on state and federal funded prevention program planning, progress, and impact. The system is designed to allow DBHR to meet current state and federal reporting requirements and is adaptable to accommodate potential future reporting and funding requirements. Since the transition from the previous Prevention MIS to the current system starting in October 2016, DBHR has engaged system users in on-going training and technical assistance to address system user's understanding of reporting requirements and how to use the new Prevention MIS. DBHR continues to work to develop system generated reports and other tools to help both DBHR staff and local prevention staff to improve data integrity, as well as work with the vendor to improve upon baseline system features.

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DBHR continues to integrate stakeholder input, including input from the Behavioral Health Advisory Council, as well as the independent peer review summaries to make data-informed needs assessment with planning, policy development, service provision, and reporting.

The State Epidemiological Outcomes Workgroup (SEOW) plays an important role in primary prevention and treatment planning. The SEOW is co-chaired by the DBHR Behavioral Health Administrator (Prevention) and the State Epidemiologist for Non-Infectious Conditions from the Department Health (DOH), and is comprised of epidemiologists from multiple state agencies and universities tasked with monitoring and improving the behavioral health of the population. DBHR is committed to ensure that tribal behavioral health needs define statewide needs by including representatives from the Northwest Portland Area Indian Health Board Epidemiological Center and the Urban Indian Health Institute as members for the SEOW. During the past year, the SEOW has identified new data sources and provided guidance, as well as data support in identifying the state's prevention priorities through the State Prevention Policy Consortium.

Washington State has implemented major policy changes, such as privatization of spirit sales and legalization of recreational marijuana, so active monitoring of key prevalence indicators and treatment needs is crucial to ensure that our services are adaptable to the changing environment. In the coming year, the SEOW will continue to assess existing data sources, identify data gaps, and develop new data sources. This criteria will be presented to the DBHR Quality Improvement Committee, DBHR Management Team, Behavioral Health Advisory Council, tribes, and stakeholder groups to contribute to these efforts.

### *Under-served Populations*

In 2013, the legislature required DSHS to submit a Tribal Centric Behavioral Health Report that included both findings and recommendations. One of the several findings concluded Medicaid enrolled AI/AN individuals have a significantly higher incidence of mental illness diagnoses than Medicaid non-natives. Across all ages, AI/AN enrollees have a 67 percent higher incidence of mental illness diagnoses than non-native enrollees. It also concluded that diagnoses of mental illness for AI/AN children was 125 percent higher than for non-native children. In addition, AI/AN children have an 84 percent higher usage of being prescribed psychotropic medications than non-native children. One of the major recommendations was the development of a tribal Evaluation and Treatment Center (E&T).

In 2015, BHA's formal consultation with Washington Tribes on the 1915 (b) Medicaid waiver resulted in DSHS committing to pursue the development of a tribal E&T to provide culturally specific services for individuals who are involuntarily committed under the Involuntary Treatment Act. A freestanding evaluation and treatment center is a residential treatment facility licensed by the Department of Health and certified by BHA to provide medically necessary evaluation and treatment to individuals who would otherwise meet hospital admission criteria. At a minimum, services include evaluation, stabilization and treatment provided by or under the direction of licensed psychiatrists, nurses and other mental health professionals, and discharge planning involving the individual, family, or significant others so as to ensure continuity of mental health care. E&T center services are provided for individuals who: 1) pose an actual or imminent danger to themselves, others, or property due to a mental illness; or 2) have experienced a marked decline in their ability to care for themselves due to the onset or exacerbation of a psychiatric disorder.

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To address this issue, the Behavioral Health Administration (BHA) submitted a budget request for \$5.2 million to build a new E&T that will specialize in culturally appropriate services for this population. The Legislature did not fund the development of the E&T. However, funding was provided for DBHR to conduct a study for the need for a culturally appropriate Tribal E&T.

In addition to culturally appropriate E&T services, the state is also addressing the lack of Psychiatric Community inpatient capacity as well as the lack of affordable housing for persons with SMI and SED.

#### *Strategy to Identify Unmet Needs and Gaps*

DBHR's planning of prevention and treatment services draws on data from various sources. The biennial statewide **Healthy Youth Survey (HYS)** provides reliable estimates of substance use prevalence and mental health status among in-school adolescents, as well as risk factors that predict poor behavioral health outcomes. The survey, supported by four state agencies and administered every two years in over 80 percent of the state's non-tribal public schools, is used by DBHR to estimate prevalence rates at state, county, Behavioral Health Organizations, Accountable Communities of Health, school districts, and even school building levels. The last HYS was conducted in the fall of 2016 which provided data for DBHR's needs assessment, including broadening surveillance capacity for LGBTQ communities, teen anxiety and substance use issues related to vapor products. The HYS will be conducted again in the fall of 2018.

For young adults, adults, and older adults, the main data sources for prevalence estimates and epidemiological analyses are **the National Survey on Drug Use and Health (NSDUH)**, **the Behavioral Risk Factor Surveillance System (BRFSS)**, and **the Washington Youth Adult Health Survey (YAHS)**. NSDUH is used to estimate and monitor substance use prevalence rates for various types of substances and BRFSS provides information to identify needs and gaps among various demographic and socioeconomic subpopulations. For example, the Washington BRFSS includes questions that allow us to identify pregnant/parenting women and the LGBTQ subpopulations. However, the small sample size limits the ability to create estimates for these subpopulations without combining multiple years of data, and the minimal number of questions about marijuana and alcohol on these surveys limits the ability to assess how recent policy changes are shaping substance use patterns. DBHR has partnered with researchers at the University of Washington to conduct the YAHS, filling these gaps with a larger sample to allow for comparison of sub-populations, and detailed questions that enable assessment of how substance use patterns are changing among young adults in the state. Moving forward, SEOW will continue to assess data for priority populations and advise on potential data sources to address these gaps.

The use of evidence-based practices (EBP) in the field of behavioral health is very well established. The Washington State Legislature has acknowledged the importance of EBPs in children's mental health. DBHR has established a partnership with the University of Washington's Evidence-based Practice Institute (EBPI) to assess the need for evidence-based practices in the children's behavioral health system. The collaboration aims to formulate EBP reporting guidelines and to monitor the use of EBPs by providers and identify gaps in EMP implementation using data from BHDS.

For specific priority subpopulations, including pregnant injecting drug users, pregnant substance abusers, injecting drug users, women with dependent children, and persons at risk for tuberculosis, data will be drawn from other state surveys and administrative databases as well as service data to identify the un-met need. For example, we will use data from the **Pregnancy Risk Assessment Monitoring System (PRAMS)** to estimate the prevalence of substance use among pregnant women and treatment

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data to identify the rate of treatment for pregnant substance users. When prevalence data is unavailable for certain priority subpopulations, such as women with dependent children, treatment data will be used to monitor rates of admission to SUD treatment. The SEOW will identify data gaps for priority subpopulations and advise on potential data sources.

At the sub-state level, we will use a synthetic process to estimate substance abuse treatment needs. This process combines data from US Census sources for geographic and demographic subgroups to “expand” the NSDUH state-level estimates of AOD treatment need into the desired subgroups (defined by poverty level, age, race/ethnicity, gender).

Detailed community level need and resource assessments will be used to develop strategic plans to support the individual, community, and local system level. In addition to HYS, the **Community Outcomes and Risk Evaluation (CORE) System** will be used in community level needs assessment. The CORE Geographic Information System (GIS), developed as a set of social indicators highly correlated with adolescent substance use, are kept at the lowest possible level (at least county level, and address level in some instances). Most indicators originate from the Department of Health, DSHS, the Uniform Crime Report, and the Office of the Superintendent of Public Instruction.

### *Strategy to Align Behavioral Health Funding with Unmet Needs and Gaps*

The funding allocation methodology for non-Medicaid services was reviewed as part of the integration of mental health and substance use disorder treatment for the Behavioral Health Organizations. Treatment needs by county, as well other factors such as utilization patterns, penetration and retention rates were also used for developing the methodology. After much review with stakeholders, the final methodology that was incorporated into the model is 70% prevalence, 20% penetration and 10% retention. Integrating these factors allows us to maintain focus on our mandated priority populations (PPW, IVDU, persons at risk of TB) and the full continuum of care, while retaining the commitment youth treatment, evidence-based practices, and statewide availability of services.

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

Using a data-based approach, the Washington State Prevention Enhancement Policy Consortium (SPE) updated in November 2017 the state’s Substance Abuse Prevention and Mental Health Promotion Strategic Plan for the next five-year period. The consortium, comprised of representatives from 25 state and tribal agencies and organizations, conducted an extensive review of state-level data on the use and misuse as well as the impact of alcohol, tobacco, marijuana, prescription drugs, and mental health status. The SEOW provided baseline data and recommendations for indicators to prioritize and will provide updates for ongoing monitoring of indicators selected by the SPE to inform any adjustment to the plan. This plan is available at <http://www.theathenaforum.org/node/8123>.

Prevention funding, under the state’s Community Prevention Wellness Initiative (CPWI) and through grants awarded to Washington State Community-based organizations (CBOs), are targeted to communities with the highest needs. The SEOW identifies highest-need communities through a risk ranking that integrates data on prevalence of and consequences related to substance use; separate rankings were developed for underage drinking, marijuana use, and all ATOD use. Using the most recent data, SEOW periodically updates the risk rankings. The most recent update was in spring 2018. Because



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the HYS and CORE data are available at the community and school level, communities and neighborhoods can be identified that otherwise might be overlooked if data were only available at larger geographic units.

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

### **Priorities**

#### **Priority 1: Reduce Underage and Young Adults Substance Use/Misuse.**

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

#### **Priority 2: Increase the number of youth receiving outpatient substance use disorder treatment**

#### **Priority 4: Increase the number of adults receiving outpatient substance use disorder treatment**

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

#### **Priority 3: Increase the number of adults with SMI receiving mental health outpatient treatment**

#### **Priority 8: Increase outpatient mental health services for youth with SED**

Mental health treatment services continue to focus on the block grant priority population: youth and young adult with serious emotional disorder (SED), adults, and older adults with serious mental illness (SMI).

#### **Priority 5: Maintain Government to Government relationships with Tribal Governments**

American Indians/Alaska Natives continue to be a priority for substance use disorder services which includes emphasis on serving the mandated priority populations (IVDU, PPW, and individuals at risk of TB). The SABG funding that the tribes receive remains at the same level.

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### **Priority 6: Increase the number of consumers receiving recovery support services, including increasing employment services and decreasing homelessness for individuals with SMI and SED**

DBHR is committed to decreasing rates of homelessness and increasing rates of employment for adults with behavioral health issues while increasing awareness and using evidence-based practices to address these needs. The primary focus will be on the mandatory SABG and MHBG priority populations (SABG IVDU, PPW, and persons at risk of TB) and (MHBG individuals with SMI and SED).

### **Priority 7: Develop a peer support program for individuals with substance use disorders**

DBHR will be piloting a SUD peer pilot project to increase the number of SUD peers working in the field that includes creating a strategic plan to incorporate SUD peer services into the behavioral health system. The primary focus will be to the mandatory priority populations that include pregnant and parenting women, persons who inject drugs, and individuals at risk of TB.

The performance indicators identified to track progress in these priority areas are aligned with recent state legislation that drives data, reporting, and performance management priorities for DBHR: (1) **Senate Bill 6312**, which directs DSHS to change how it purchases mental health and substance use disorder services; and (2) **House Bill 1519** and **Senate Bill 5732**, which direct DSHS and the Health Care Authority (HCA) to carry out multiple activities focused on improving the outcomes of adults who receive behavioral health services, including the establishment of accountability measures.

HB1519 and SB5732 mandated that the state contract with “service contracting entities” or “service coordination organizations” (i.e., Regional Support Networks, county chemical dependency coordinators, the Area Agencies on Aging, and the managed health care plans) to include specific performance measures to address outcomes in the following areas:

- Improvement in client health status
- Increases in client participation in meaningful activities, including employment and education
- Reduced client involvement with the criminal justice system and increased access to treatment for forensic patients
- Reduced avoidable costs in hospitals, emergency rooms, crisis services, and jails/prisons
- Increased housing stability in the community
- Improved satisfaction with quality of life including measures of recovery and resilience
- Decreased population level disparities in access to treatment and treatment outcomes

The performance indicators used to monitor our progress in our seven priority areas are also aligned with **Results Washington**, which is Washington Governor Jay Inslee's data-driven performance management and continuous improvement system. Within Results Washington, DBHR has the lead responsibility for six success metrics under the Healthy Youth and Adults success indicators. DBHR's Results Washington success metrics include:

- Increase the percentage of mental health consumers receiving a service within 7 days after discharge from inpatient settings from 53.3% (January 2015 average) to 65% by June 2017.

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- Contain the percentage of 10th graders who report using marijuana in the past 30 days at 18% from January 2015 through July 2018.
- Decrease the percent of 10th graders who report drinking alcohol in the last 30 days from 21% to 19% by January 2018.

In addition to the performance indicators above, the state is also tracking MH and SUD service utilization data prior to the implementation of the BHOs and post BHO implementation.

- The target for adults receiving mental services based on RSN utilization trends was set at 50,396. Based on data through January 2017, the state has exceeded this target and has served 54,307 adults.
- The target for children receiving mental services based on RSN utilization trends was set at 19,533. Based on data through January 2017, the state has exceeded this target and has served 21,942 children.
- The target for adults receiving substance use disorder services prior to implementation of the BHOs was 23,868. Based on data through January 2017, the state has not met the target and has served 22,524 adults. However, the state is still resolving issues with completeness of detox and inpatient data after implementation of the BHOs.
- The target for children receiving substance abuse services prior to implementation of the BHOs was set at 1,481. Based on data through January 2017, the state has exceeded this target and has served 1,856 children.

Aligning our Block Grant performance indicators with these efforts allows DBHR to strategically focus on these critical priorities.