

DECEMBER 2022-2023

# SUBSTANCE USE AND RECOVERY SERVICES PLAN

Developed by the Substance Use  
and Recovery Services Advisory  
Committee in collaboration with

Washington State  
Health Care Authority



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## Acknowledgements

The Washington State Health Care Authority would like to acknowledge and give our deepest gratitude to those who have and who are currently serving on the Substance Use and Recovery Services Advisory (SURSA) Committee. Through their guidance and subject matter expertise during the planning and development of the Substance Use and Recovery Services Plan, HCA has been able to submit this robust and forwardthinking plan to help Washingtonians affected by drug use and substance use disorders (SUD). Their enthusiasm, eagerness for collaboration, grace, and time has been invaluable to the proces of this plan development.

*Table 1: Current SURSA Committee roster*

<b>Michael Langer</b> Director's appointment	<b>Lauren Davis</b> House of Representatives Democrat	<b>Dan Griffey</b> House of Representatives Republican
<b>Manka Dhingra</b> Senate Democrat	<b>John Braun</b> Senate Republican	<b>Amber Leaders</b> Governor's Office
<b>Caleb Banta-Green</b> Addictions, Drug & Alcohol Institute at UW	<b>Julian Saucier</b> Adult in recovery from SUD who experienced criminal legal consequences	<b>Amber Daniel</b> Peer recovery services provider
<b>Brandie Flood</b> Anti-racism member	<b>Stormy Howell</b> Representative of a federally recognized Tribe	<b>Chad Enright</b> Prosecutors Office
<b>John Hayden</b> Public defender	<b>Kevin Ballard</b> Local government	<b>Sarah Melfi-Klein</b> Association of Washington Health Plans
<b>Sherri Candelario</b> Recovery housing provider	<b>James Tillett</b> Outreach services provider	<b>Christine Lynch</b> SUD treatment provider
<b>Sarah Gillard</b> Representative of experts serving people with co- occurring SUD and mental health conditions	<b>Donnell Tanksley</b> Washington Association of Sheriffs and Police Chiefs	<b>Malika Lamont</b> Representative of experts on the diversion from the criminal legal system to community-based care for people with SUD
<b>Chenell Wolfe</b> Adult in recovery from SUD who experienced criminal legal consequences	<b>Alexie Orr</b> Adult in recovery from SUD who experienced criminal legal consequences	<b>Hunter McKim</b> Youth in recovery from SUD with criminal legal consequences
<b>Kendall Simmonds</b> Youth in recovery from SUD with criminal legal consequences		<b>Addy Adwell</b> SUD provider Union member

## Health equity in tribal and rural areas

When considering services across the state of Washington, special attention is given to select areas, including those in rural counties, that have less access to amenities and services than those in urban areas. The current system that makes the distinction between these two types of counties is built on the decennial censuses and may not be comparable due to methodological changes and absence of bridging data among census decades. There is also notice taken into the differences in health status indicators between rural and urban residents that might reflect underlying differences in the economic and socio-demographic characteristics in these regions. When the recommendations of these plans are considered and developed, distinction and consideration is given to meet the needs of these areas.



The Committee further dedicates itself to adhere to the principles of health equity and justice for American Indian/Alaskan Native (AI/AN) communities, people of color, and other affected populations. The Committee provides representation from various populations, while working in collaboration with AI/AN, people of color, and other populations that have been oppressed by dominant culture. The Committee has examined strategies and activities to understand how current work can be used to address inequities in substance use disorder, treatment, and recovery services. Voices in subcommittees provided an avenue to understand cultural barriers to treatment and recovery and examine what we can do in the future to provide meaningful, culturally appropriate services.

We recognize that input from tribes and tribal organizations (AI/AN), people of color, and other affected populations is essential to help guide our initiative developed out of the Engrossed Senate Bill 5476, in a way that respects the culture and traditions of individual communities and impacts of systemic racism.



## Executive summary

In 2016, an individual was arrested. Upon jail booking, a corrections officer found a small amount of methamphetamine in their clothing. They were subsequently charged and convicted of Unlawful Possession of Controlled Substance under [RCW 69.50.4013](#). The individual appealed the ruling and argued that they did not know there was methamphetamine in the jeans, which were gifted from a friend two days prior.

On February 25, 2021, the Washington State Supreme Court vacated the conviction and ruled the Controlled Substance Statute unconstitutional, stating RCW 69.50.4013 violates the due process clause as it does not protect individuals who unknowingly were in possession of a substance.

This ruling, and the resulting decriminalization of controlled substance possession, led to the passing of Engrossed Senate Bill 5476 and the creation of the Substance Use Recovery Services Advisory (SURSA) Committee and eventual substance use recovery services plan.

This plan was developed on behalf of the Washington State Health Care Authority (HCA) and made by the Substance Use Recovery Services Advisory (SURSA) Committee, as outlined in [Engrossed Senate Bill 5476 \(2021\)](#): Responding to the State v. Blake decision by addressing justice system responses and behavioral health engagement, treatment, and recovery services.

“The authority, in collaboration with the substance use recovery services advisory committee established in subsection (2) of this section, shall establish a substance use recovery services plan. The purpose of the plan is to implement measures to assist persons with substance use disorder in accessing outreach, treatment, and recovery support services that are low barrier, person centered, informed by people with lived experience, and culturally and linguistically appropriate. The plan must articulate the manner in which continual, rapid, and widespread access to a comprehensive continuum of care will be provided to all persons with substance use disorder.”

*Table 2: ESB 5476 deliverable timeline*

Deliverable	Date
Preliminary report to HCA	November 24, 2021
Final plan submitted to Governor and Legislature	December 1, 2022
Annual Plan Implementation Report to Governor and Legislature	December 1, 2023, and each subsequent year until 2026
Adopt rules/contract necessary to implement the plan	December 1, 2023

## Subcommittees

The SURSA Committee (Committee) acknowledged in March 2022 that there was a need for more Committee time and more expertise to advise the recommendations requested for the Substance Use Recovery Services Plan (Plan); see [Appendix A](#). HCA wants to acknowledge subcommittee participation, involvement, commitment, and expertise provided to inform the recommendations put forth for the Plan.

Participation in the subcommittee included:

- ❖ Voices of Community Activists and Leaders - Washington (VOCAL-WA), along with the community members who VOCAL-WA brought to the table to share their lived and living experience.
- ❖ Law Enforcement Assisted Diversion (LEAD) National Support Bureau and technical assistance team
- ❖ Washington State Association of Sheriffs and Police Chief (WASPC)
- ❖ Members of Washington Alliance for Quality Recovery Residences (WAQRR)
- ❖ Washington State Association of Drug Court Professionals (WSADCP)
- ❖ University of Washington, including Addictions, Drug & Alcohol Institute (ADAI) and supporting staff.
- ❖ Behavioral health administrative service organizations (BH-ASOs)
- ❖ Recovery Navigator Program (RNP) administrators.
- ❖ Department of Health employees
- ❖ Department of Commerce employees
- ❖ Washington residents with lived and living experience
- ❖ Employees of the Department of Social and Health Services (DSHS)
- ❖ Employees of the Department of Children, Youth, and Families (DCYF)
- ❖ Employees of HCA
- ❖ Community-based organizations
- ❖ Washington Low Income Housing Alliance

Figure 1: Timeline outline

## Timeline outline: Substance Use and Recovery Services (SURS) plan



### CREATION OF SURSA COMMITTEE

ESB 5476 instructs the Authority to establish a Substance Use and Recovery Services (SURSA) Committee comprised of individuals with relevant background related to the needs of persons with substance use disorder. 26 members were selected and the first, introductory, meeting was held on December 6, 2021.



### REQUEST FOR SUBCOMMITTEES

Members of the SURSA Committee identified the immediate need for more time and additional resources and community contribution to inform the recommendations for a plan of this magnitude. In March, four subcommittees were developed, data, recovery support services, treatment, and outreach, engagement, and diversion.



### START OF SUBCOMMITTEES

Though the recovery support services subcommittee started meeting in March, majority of the subcommittees started meeting in April. Committee members volunteered as co-chairs for each meeting along side supportive HCA employees.



### VOTING ON RECOMMENDATIONS

June 2022, began the reviewing and voting on the recommendations brought forth by the subcommittees for review. Once reviewed and edited, recommendations are voted on to be included into the substance use and Recovery Services plan.



### FINAL SUBMISSION AND VOTING

October 2022, SURSA subcommittees worked diligently along side HCA supporting staff to curate and delivery over 15 thoughtful and meaningful approaches to provide and delivery widespread access to the continuum of care across Washington.



## Contextual setting

Below are various terms and definitions used in the realm of substance use, that will provide contextual background to gain a greater understanding of the work described in the plan. The SURSA Committee and subcommittees provided feedback and guidance surrounding these definitions.

**Harm reduction:** Harm reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. Harm reduction is also a movement for social justice built on a belief in, and respect for, the rights of people who use drugs.<sup>1</sup> Harm reduction involves safer use of supplies as well as care settings, staffing, and interactions that are person-centered, supportive, and welcoming.<sup>2</sup>

**Recovery:** Recovery is a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential.

**Recovery support services (RSS):** A collection of resources that sustain long-term recovery from substance use disorder, including for people with co-occurring substance use disorders and mental health conditions, recovery housing, permanent supportive housing, employment and education pathways, peer supports and recovery coaching, family education, technological recovery supports, transportation and childcare assistance, and social connectedness.

**Recovery residences:** Recovery housing benefits individuals in recovery by reinforcing a substance-free lifestyle and providing direct connections to other peers in recovery, mutual support groups and recovery support services. Substance-free does not prohibit prescribed medications taken as directed by a licensed prescriber, such as pharmacotherapies specifically approved by the Food and Drug Administration (FDA) for treatment of opioid use disorder and/or for the treatment of co-occurring disorder.

**Low threshold-low barrier treatment:** Increasing access to behavioral health-related services and programs by creating person-centered programs that are easy to access, offer a high quality of care, and eliminate barriers associated with accessing or remaining in behavioral health treatment and related services. Elements include:

- Short time to the start of necessary medication (same day for most)
- Polysubstance use allowed initially and ongoing
- Counseling always offered, not mandated
- Urine drug screens are used to inform clinical care<sup>3</sup>

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<sup>1</sup> <https://harmreduction.org/about-us/principles-of-harm-reduction/>

<sup>2</sup> This term as normally presented excludes practice-based evidence developed and promulgated by indigenous communities for generations. The Western model considers evidence in a narrower context than indigenous communities.

<sup>3</sup> <https://www.learnabouttreatment.org/for-professionals/low-barrier-buprenorphine/>

## Committee recommendations overview

Recommendations are numbered according to the order in which they were voted on by the Committee. Recommendation #17 – [an amendment to the Good Samaritan Law](#) – is not included, as it did not receive SURSAC support.

### Data

Table 3: Data recommendations

Recommendation	Type
Recommendation 6: <a href="#">BH-ASO and RNP data reporting</a>	Policy/Funding
Recommendation 13: <a href="#">LE and BH data collection and reporting</a>	Policy/Funding

### Diversion, outreach, and engagement

Table 4: Diversion, outreach, and engagement recommendations

Recommendation	Type
Recommendation 10: <a href="#">Expanding investment in programs along the 0-1 intercept on the sequential intercept model</a>	Funding
Recommendation 12: <a href="#">Stigma-reducing outreach and education, more importantly regarding youth and schools</a>	Policy/Funding
Recommendation 5: <a href="#">Amend RCW 69.50.4121 – Drug paraphernalia law</a>	Policy

### Treatment

Table 5: Treatment recommendations

Recommendation	Type
Recommendation 7: <a href="#">Health Engagement Hubs for People Who Use Drugs</a>	Funding
Recommendation 14: <a href="#">Safe supply workgroup</a>	Funding
Recommendation 11: <a href="#">SUD engagement and measurement process</a>	Policy/Funding
Recommendation 15: <a href="#">Expanding funding for OTPs to include partnerships with rural areas</a>	Funding

### Recovery support services

Table 6: Recovery support services recommendations

Recommendation	Type
Recommendation 1: <a href="#">Tax incentives for landlords and respite space housing vouchers</a>	Policy/Funding
Recommendation 3: <a href="#">LGBTQIA+ community housing</a>	Policy/Funding
Recommendation 4: <a href="#">Training of foster and kinship parents of children who use substances</a>	Policy/Funding

Recommendation 16: <a href="#">Addressing zoning issues regarding behavioral health services</a>	Policy/Funding
Recommendation 2: <a href="#">Legal advocacy for those affected by SUD</a>	Policy/Funding
Recommendation 8: <a href="#">Employment and education pathways</a>	Funding
Recommendation 18: <a href="#">Continuum of housing</a>	Funding
<a href="#">Recommendation 9: Expansion of WRHL and asset mapping</a>	Funding

Recommendation regarding the appropriate criminal legal system response, if any, to possession of controlled substances.

One of the more visible requirements of the SURS plan was the Committee’s development and consideration of recommendations for an appropriate criminal legal response to possession of a controlled substance. What follows is the outline and strategies behind the development and eventual consensus surrounding a recommendation for this legislative request.

RCW 71.24.546§1 - The authority, in collaboration with the substance use recovery services advisory committee, established in subsection (2) of this section, shall establish a substance use recovery services plan. The purpose of the plan is to implement measures to assist persons with substance use disorder in accessing outreach, treatment, and recovery support services that are low barrier, person centered, informed by people with lived experience, and culturally and linguistically appropriate. The plan must articulate the manner in which continual, rapid, and widespread access to a comprehensive continuum of care will be provided to all persons with substance use disorder.

*The plan must consider: (RCW 71.24.546§3§I) Recommendations regarding the appropriate criminal legal system response, if any, to possession of controlled substances.*

Preliminary discussions surrounding this recommendation from the SURSA Committee produced considerations for various types of data that would assist in a meaningful recommendation. Data sets were identified as:

- ❖ Analysis of the racial impact of decriminalization of possession versus legalization of supply through review of national and international models
- ❖ Current state of the criminal legal system and how it is either being used to incarcerate or used as leverage for individuals to enter treatment, and successfully complete treatment
  - What are the effects, and intent versus outcomes
- ❖ Outcomes data for drug court participants, including analysis of racial outcomes
- ❖ Study of systemwide impacts on the community

- ❖ Research data on the efficacy of behavioral health interventions embedded within the criminal legal system
- ❖ Analysis of gaps in current system to take care of the individual diverted due to decriminalization, into health care, child protective services (CPS), foster care, etc.
  - Looking at gaps where services are not available, like in rural areas
- ❖ Health care cost savings for individuals who are diverted to harm reduction and low-barrier services
- ❖ Inclusivity (nature of the crime, race) of individuals in diversion programs and their outcomes
- ❖ Summary of which areas in the state are offering diversion programs for youth
- ❖ Considerations of social determinants of health and the criminal legal system
- ❖ Data on Involuntary Treatment Act (ITA), crisis stabilization centers and inpatient treatment programs are working outside of the criminal system
- ❖ Data comparison from what was or was not working prior to State v. Blake and the current statute

A comprehensive resource document was created and distributed to the SURSA Committee for their review. The document detailed the various areas where data had been made available, based on those data requirements outlined by the Committee. See [Appendix S](#).

On August 8, 2022, the SURSA Committee met during a regularly scheduled monthly meeting and participated in a straw poll exercise to assign a hierarchy of preference regarding proposed recommendations. Table 7 summarizes the concepts discussed and voted on as the more comprehensive components and direction for the recommendation.

Table 7: Preliminary votes on initial concepts and ideas regarding possession

14 Votes	• Safe supply initiative
12 Votes	• Maintain possession of a controlled substance as a misdemeanor with diversion options
9 Votes	• Decriminalize possession of controlled substances and paraphernalia with no civil penalty or fines
8 Votes	• Decriminalize possession of controlled substances and paraphernalia and make it a civil penalty
8 Votes	• Legalize possession of all controlled substances/create a regulated market
4 Votes	• Maintain possession of a controlled substance as a gross misdemeanor with diversion options
2 Votes	• Make possession of a controlled substance a felony, with diversion eligibility
1 Vote	• Maintain possession of a controlled substance as a misdemeanor, punishable only by fine
1 Votes	• Make possession of a controlled substance a felony

The Committee requested additional time and resources to assist in advising the Committee on implications related to the various components that may go into this recommendation. A special Committee meeting was held on September 9, 2022, that consisted of various presentations from:

- American Civil Liberties Union (ACLU) summary of Policy Strategies from Commit to Change Washington and the Pathways to Recovery Act
- LEAD Technical Assistance Team on pre-arrest diversion strategies from LEAD, RNP, and Arrest and Jail Alternatives (AJA)
- University of Washington on safe supply models
- Oregon Health Justice Alliance on decriminalization successes and lessons learned regarding Oregon Measure 110
- VOCAL- WA on disparity and inequity in criminal legal response to possession.

Through these presentations, common elements were identified to be incorporated with any recommendation made by the Committee.

Table 8: Common elements for recommendation of possession

Common elements that are required for any response to possession			
❖ Safe supply	❖ Law enforcement assisted diversion and referral options	❖ Investments in the behavioral health workforce and infrastructure for outreach, treatment, and recovery services	❖ Investment in harm reduction and low barrier engagement services

The gravity of this recommendation was taken very seriously by Committee members. While data and additional meeting time was provided, some Committee members voiced concern that there were some missed opportunities for a deeper understanding of the options developed and discussed by the Committee.

The Committee made a final decision on this recommendation: *Decriminalize possession of controlled substances and paraphernalia with no civil penalty or fines.*

## Data

Data requirements were identified early on as integral to a significant portion of the outlined plan requirements, in addition to discussions about addressing the criminal legal response to possession but also. This data subcommittee was tasked with considering the Health Care Authority ProviderOne and [Behavioral Health Data System](#) (BHDS) data collection systems as well as informing new data collection parameters for the various programs within ESB 5476, such as Recovery Navigator Program (RNP). The subcommittee addressed current concerns regarding data collection while it developed recommendations that met the various requirements outlined in RCW 71.24.546§3. These recommendations meet statutory requirements found in (§1.3.h) and (§1.3.m):

(1)“ (3) The plan must consider:

(h) The design of recovery navigator programs in section 2 of this act, including reporting requirements by behavioral health administrative services organizations to monitor the effectiveness of the programs and recommendations for program improvement;

(m) Recommendations regarding the collection and reporting of data that identifies the number of persons law enforcement officers and prosecutors engage related to drug possession and disparities across geographic areas, race, ethnicity, gender, age, sexual orientation, and income. The recommendations shall include, but not be limited to, the number and rate of persons who are diverted from charges to



recovery navigator services or other services, who receive services and what type of services, who are charged with simple possession, and who are taken into custody;”

Below are the recommendations and outlined plans of action developed from this subcommittee and approved by the SURSA Committee.

SURSA Committee recommendations

Recommendation 6: Behavioral Health Administrative Service Organization (BH-ASO) and Recovery Navigator Program (RNP) data reporting

The Committee recommends establishing specific data collection and reporting requirements among behavioral health administrative services organizations (BH-ASOs) related to their regional recovery navigator programs (RNPs). This recommendation also requests to identify data to be included in the RNP quarterly reports for SURSAC review to monitor program effectiveness and inform recommendations for improvements. The recommendation addresses ESB 5476 Section 1.3(h), related to “reporting requirements by behavioral health administrative service organizations to monitor the effectiveness of the programs and recommendations for program improvement.”

As a key aspect of the Plan and the state’s response to the State v. Blake supreme court ruling, the Recovery Navigator Program was initiated as soon as possible following the passing of ESB 5476. [Uniform Program Standards](#) were established, and HCA developed a draft data collection workbook for use by the BH-ASOs and RNP contractors. The BH-ASOs have contracted with local providers and community-based organizations, and those providers have hired staff who are collecting those data which are being tracked in the data collection workbook.



This recommendation requests to:

- ❖ Seek funds to implement a data integration platform that can serve both as a common database for diversion efforts across the state and as a data

collection and management tool for practitioners. If possible, leverage existing platforms already in use by HCA-funded efforts and any closed loop referral systems implemented in the future.

- ❖ Establish a quality assurance process for BH-ASOs to ensure that data in the data collection workbooks are clean, complete, and accurate before submitting to HCA, and a plan in place for data that is deemed unverified for submission
- ❖ Where applicable, add data validation to data fields in the data collection workbook (e.g., only dates accepted under DOB and date of referral, only 7-digit numbers accepted in ProviderOne ID, etc.)

It is expected that individuals served by RNP will be engaged in long-term, intensive case management. While some “light touch” participants could see significant individual benefits in a relatively short period of time, many individuals will have complex co-occurring challenges, including extensive criminal-legal system contact. For these participants, progress toward health, wellness, and stability is expected to take much longer than a year, so evaluations of the RNP in its early years should include determining measures and measures of change (in knowledge, attitudes, or actions) for systems stakeholders, not only data that can assess participant-level formative and outcome metrics.

While the impacts of a systems-change initiative like RNP are unlikely to be seen within the first few years, Washington State should currently work to establish the necessary capacities and processes to enable both formative evaluation and summative evaluation of effectiveness. This will likely require the integration of a new data infrastructure or processes that can exploit existing and new streams of data pertaining to an individual’s criminal legal system encounters/involvement, and the outreach, treatment, and recovery support services they receive through RNPs.

See [Appendix G](#).

#### Recommendation 13: Law Enforcement (LE) and Behavioral Health (BH) data

The recommendation requests building upon, and providing ongoing funding for, a data integration infrastructure that can receive and analyze standardized data gathered by law enforcement, courts, and prosecutors; Recovery Navigator Program case management; behavioral health treatment services; and recovery support services, to meet the mandates of Section 1.3(m) “regarding the collection and reporting of data which identify the number of persons law enforcement officers and prosecutors engage related to drug possession and disparities across geographic

areas, race, ethnicity, gender, age, sexual orientation, and income. The recommendations shall include, but are not limited to, the number and rate of persons who are diverted from charges to recovery navigator services or other services, who receive services and what type of services, who are charged with simple possession, and who are taken into custody.”

The focus in this recommendation is on a general data infrastructure for reporting key indicators. Data is being collected in various sectors and programs related to substance use and behavioral health systems (law enforcement encounters, treatment, recovery support services programs, Recovery Navigator Program, etc.)

Many of those data systems do not have a consistent identifier across systems, or consistent standards for data collection and classification, which creates redundancies and makes it difficult to link the data between sectors. This hinders understanding of the patterns taking place among different communities and their outcomes following an encounter with law enforcement. Consistent data gathering and integration methodologies such as those described in this recommendation would meet the data mandates of 1.3(m). A data integration infrastructure such as the one described in this recommendation has been implemented in four Law Enforcement Assisted Diversion (LEAD) pilot sites per [RCW 71.24.589](#) (Whatcom, Snohomish, Mason, and Thurston counties) and three [Arrest and Jail Alternatives](#) grantee sites per [RCW 36.238A.450](#) (Olympia, Port Angeles, Walla Walla).

In addition to the legislative mandated collection of data addressed above, the following data suggestions to be collected and reported are:

#### System utilization

- Use of emergency medical services
- Arrest, days in jail
- New charges with incident date after of referral to RNP (divided by felony, misdemeanor), to be added to Case Management tab in RNP Data Collection tool
- Convictions with incident date after date of referral to RNP (broken into felony / misdemeanor), to be added to Case Management tab in RNP Data Collection tool
- Access to and engagement with culturally appropriate, non-punitive, community-based resources

#### System response

- Capacity and variety of local services aligned with RNP’s commitment to harm reduction and holistic care

- Number and percent of substance possession-related law enforcement encounters (e.g., public order) that result in arrest, booking, and/or convictions for RNP-eligible behaviors, as well as the demographics of those individuals engaged by law enforcement in these encounters
- Racial disparity analysis that compares demographics of individuals who are arrested and booked into jail, compared to the demographics of those who are referred to RNP, among diversion-eligible individuals

### Quality of life

- Self-report quality life/well-being
  - Improved mental and physical health
- ❖ Services and access gap analysis: indicated by comparing services needed/requested by RNP participants, referrals made, referred services received by BH-ASO region, and reasons why services were not received (if applicable). If the data collection burden for case managers is too great for this level of analysis, request that case managers report areas where service gaps are a persistent problem.
  - ❖ RNP participant satisfaction: collected via survey every six months following enrollment in RNP, with procedures in place outlining minimum and maximum contact efforts.

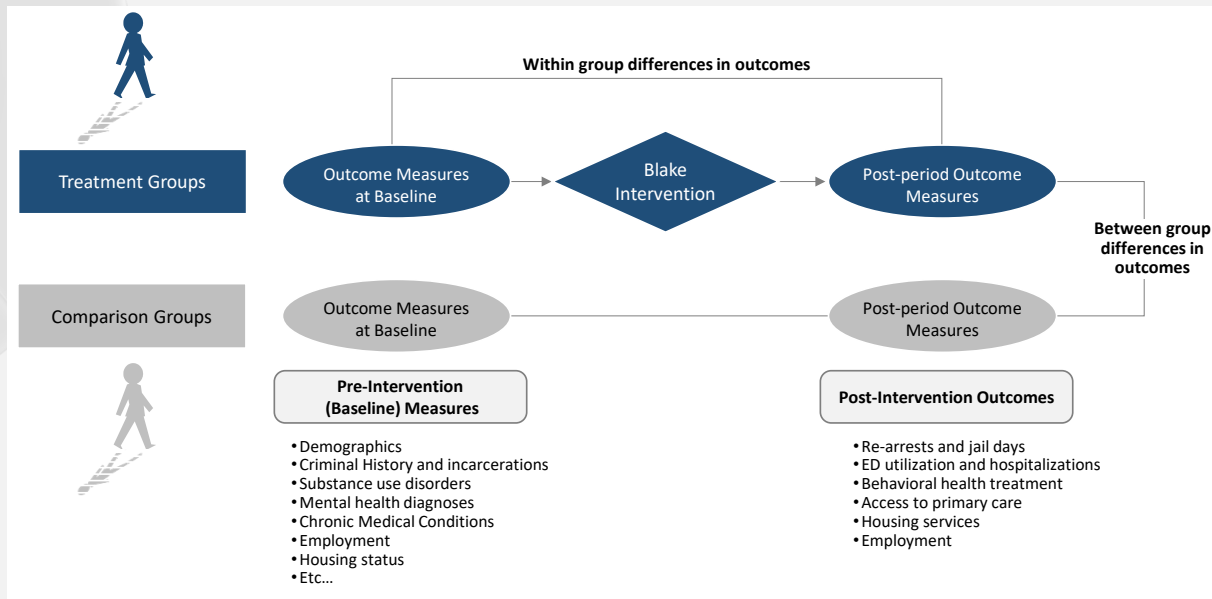
See [Appendix N](#).

## Evaluation Recommendations for the Blake-bill Interventions

Department of Social and Health Services (DSHS) Research and Data Analysis Division (RDA), provided an evaluation recommendation for programs developed from the Blake bill decision. The programs included in this evaluation recommendation include Recovery Navigator Program (RNP), Medication for Opioid Use Disorder (MOUD) in Jails, Peer-Run and Clubhouse Services Expansion, Homeless Outreach Stabilization Transition (HOST) Expansion, and Substance Use Disorder Family Navigators.

The RDA-recommended evaluation strategy focuses on efficiently estimating the impact of each Blake intervention on the above outcomes to inform decision makers about their overall and relative effectiveness. RDA recommends a general analysis of outcomes broadly applicable to all Blake interventions; program-specific strategies/outcomes may be further developed with input from the evaluator, RDA, program staff, and other individuals designated by HCA.

To efficiently estimate the effectiveness of the Blake interventions, RDA recommends a strategy that employs similar methods across the programs and focuses on a common set of relevant outcomes. The quasi-experimental evaluation will compare the outcomes of service recipients “enrolled” in each intervention (treatment group) with the experiences of statistically similar individuals who were not enrolled in the intervention (comparison group) and then draw inferences about the effectiveness of a specific intervention.



The specific construction of each outcome measure (e.g., number of arrests per year, arrest rates, felony arrests, months of SUD treatment, etc.) will be determined in collaboration with the evaluator, RDA, program staff, and other individuals designated by HCA. Baseline descriptions of program participants and propensity score matching will be possible as soon as a sufficient number of clients are enrolled in any given program.<sup>4</sup>

Typically analyses of this type employ 12- to 18-month pre- and post- periods to characterize outcomes. The time periods to be used in these analyses will depend on reporting deadlines, implementation schedules, and lags in the availability of data for specific outcome measures.

HCA program managers should work closely with service providers and RDA to ensure this information is routinely and systematically collected and maintained in a medium that supports the efficient transmission of data. Some programs collect information on disparate spread sheets; others, such as the RNP, utilize sophisticated case management software. Future opportunities for analyses on the relative effectiveness

<sup>4</sup> The “sufficient” number of participants will depend on the expected effect size of any given intervention. Interventions expecting large effect sizes require small samples.

of different intervention service components may be possible for programs that collect sufficient additional information on their clients.

See [Appendix T](#).

## Diversion, outreach, and engagement

Diversion services were one of the most crucial components of addressing ESB 5476 and the Blake decision. The legislation led to the creation of the [Recovery Navigator Program](#), providing regional resources to law enforcement diverted individuals to help access care. This subcommittee was tasked with developing ideas on diversion along with the subsequent engagement and outreach components of the plan. These recommendations meet statutory requirements found in: (§1.3.a) and (§1.3.g).

(1)" (3) The plan must consider:

(a) The points of intersection that persons with substance use disorder have with the health care, behavioral health, criminal, civil legal, and child welfare systems as well as the various locations in which persons with untreated substance use disorder congregate, including homeless encampments, motels, and casinos;

(g) Framework and design assistance for jurisdictions to assist in compliance with the requirements of RCW 10.31.110 for diversion of individuals with complex or co-occurring behavioral health conditions to community-based care whenever possible and appropriate, and identifying resource gaps that impede jurisdictions in fully realizing the potential impact of this approach;"

Below are the recommendations and outlined plans of action developed by this subcommittee and approved by the SURSA Committee.

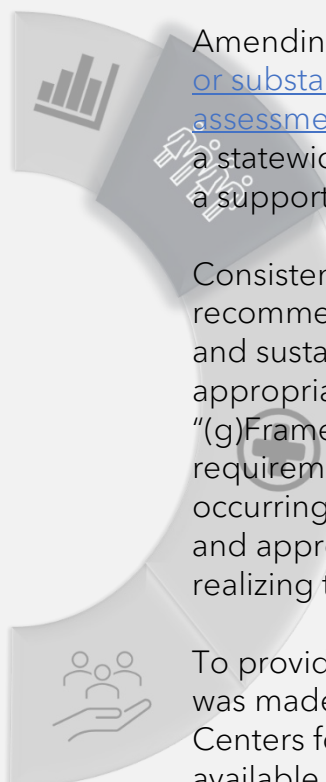
### SURSA Committee recommendations

Recommendation 10: Expanding investment in programs along the 0-1 intercept on the sequential intercept model

The SURSA Committee recommends continued and increased investments in evidence-based diversion programs that operate along intercepts 0 and 1 on the sequential intercept model<sup>5</sup>, including, the Recovery Navigator Program, Arrest/Jail Alternative programs, LEAD, and other harm reduction, trauma-informed, and public health-based approaches. These programs and interventions center around a racial justice lens for providing support to underserved communities and populations.

<sup>5</sup> For More information on the Sequential Intercept Model: <https://www.prainc.com/sim/>





Amending [RCW 10.31.110 \(Alternatives to Arrest - Individuals with mental disorders or substance use disorders\)](#) and [RCW 10.31.115 \(Drug Possession - Referral to assessment and services\)](#) would reflect how these programs should be used as part of a statewide arrest and jail diversion system by mandating availability of services within a supportive network of care.

Consistent with the Plan requirement outlined in RCW 71.24.546§3(i), this recommendation requests shifting funding from the punishment sector to increase and sustain investments to ensure equitable distribution of, and access to, culturally appropriate, non-punitive, community-based resources, including treatment. “(g) Framework and design assistance for jurisdictions to assist in compliance with the requirements of RCW 10.31.110 for diversion of individuals with complex or co-occurring behavioral health conditions to community-based care whenever possible and appropriate, and identifying resource gaps that impede jurisdictions in fully realizing the potential impact of this approach.”

To provide services, outlined below, to the Washington youth population, the request was made to provide adequate policy changes to address systemic barriers, and Centers for Medicaid Services (CMS) State Plan Amendment, for services made available to youth starting at the age of 13, the minimum Medicaid enrollee age without an adult, and incorporate Medication for Opioid Use Disorder (MOUD) accessibility and coverage.

A range of services are noted as diversion options, those services are:

- Crisis stabilization units for youth and adults
- Triage facilities for youth and adults
- Designated 24/7 crisis responders
- Mobile crisis response services for youth and adults
- Regional entities responsible for receiving referrals

In addition, these services should be made available in all regions as well:

- ASAM-alternative SUD Assessments for youth and adults
- Syringe service programs for youth and adults
- Health Hubs for youth and adults who use drugs
- Detox/withdrawal management for youth and adults
- MOUD for youth and adults
- Outpatient treatment for youth and adults
- Ensure that long-term harm reduction-supported case management is available after diversion so that diversion becomes meaningful

See [Appendix K](#).

## Recommendation 12: Stigma-reducing outreach and education regarding youth and schools



Providing education related to naloxone administration and overdose identification in Washington State public schools (grade 6 - 12) helps to reduce stigma and save lives. Outlined in §1.3.a, this recommendation would provide substantial preventative and life-saving recognition and training in the administration of naloxone for students, administrators, teachers, and other

educational professionals, at points of intersection for those that may be affected, or know someone who is affected, by SUD.

In 2019-2020, youth under 24 years saw the highest increase in mortality, 59 percent, compared to other age groups. With the dramatic increase in substance use mortality, it is imperative to reduce the discrimination and judgment leveled against youth and young adults who use drugs. This may be achieved through practical strategies including, but not limited to naloxone distribution within school settings, overdose education, evidenced-based drug safety curriculum starting at the sixth grade, and partnerships with other community organizations that advance the health and well-being of young people. [Safety First](#) is an example of learning curricula for young people that is evidenced based and/or promising practice. The SURSA Committee noted additional policy and statutory amendments were necessary to help support efforts to expand services to youth and eliminate the stigma directed at people who use illicit substances.

[RCW 69.50.412: Prohibited acts: E–Penalties. \(wa.gov\)](#) prohibits the distribution of hypodermic syringes to people under the age of 18. This RCW prohibits entities and/or individuals from distributing intramuscular syringes needed for naloxone administration. Intramuscular naloxone is currently substantially cheaper than nasal formulations – being limited by cost and access of naloxone due to RCWs may exacerbate any disparities of substance use mortality among persons under the age of 18. This law will need a technical amendment to remove barriers to life saving medication.

Stocking a “standing order” (as defined in [RCW 69.41.095](#)) of “opioid overdose reversal medication” (e.g., Naloxone) is required via [RCW 28a.210.390](#) to be stocked in high schools (grades 9-12) already for school districts with more than 2,000 students. These medications can be administered by a school nurse, a health care professional, or trained staff person located at a health care clinic on public school property under contract with the school district or designed trained school personnel. Funding would need to be provided to increase naloxone and overdose education among school aged young people (grades 6 - 12), which includes funds related to outreach and communication.

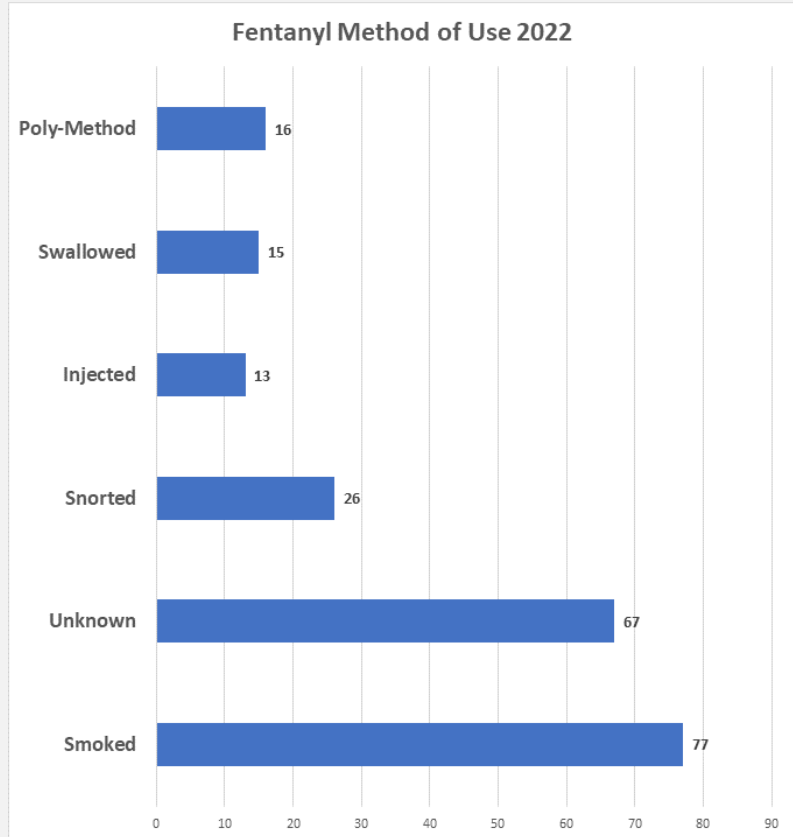
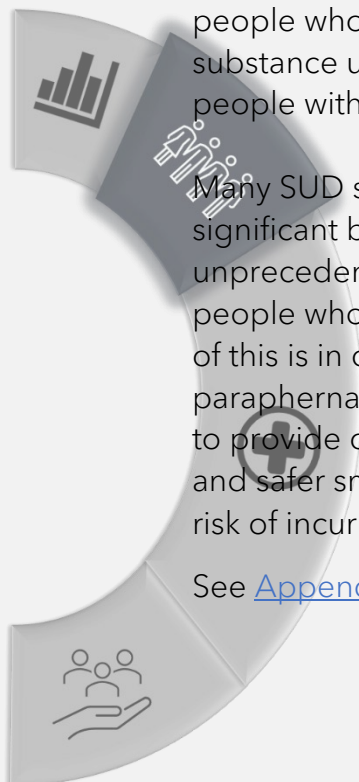


Figure 2: 2022 King County medical examiner data

See [Appendix M](#).

Recommendation 5: Amend RCW 69.50.4121 - Drug paraphernalia law

The SURSA Committee recommends amending [RCW 69.50.4121](#) to remove language that prohibits “giving” or “permitting to give” drug paraphernalia in any form, so that programs that serve people who use drugs do not risk class I civil infraction charges for providing life-saving supplies needed for comprehensive drug checking, safer smoking equipment, and other harm-reduction supplies to engage and support people who use drugs. The Committee recommends the state expressly preempt the field in Washington State regarding any penalties imposed for selling/giving paraphernalia per RCW 69.50.4121. Applying this amendment will support low-barrier, person-centered outreach and treatment services that improve safety for



people who use drugs, considering the points of intersection that people with substance use disorder have with behavioral health systems and the places where people with untreated substance use disorder congregate (Section 1.3(a)).

Many SUD service programs, especially harm reduction programs, are experiencing significant barriers adapting to accommodate changing drug use patterns and unprecedented surge of deaths from overdose, and to engage equitably with all people who use drugs and in all manners of ways that people are using drugs. Much of this is in due to paraphernalia laws that prohibit the distribution of drug paraphernalia in any form. Amending this RCW would allow harm reduction programs to provide drug testing equipment, including but not limited to fentanyl test strips, and safer smoking equipment to engage and support people who use drugs without risk of incurring a class I civil infraction.

See [Appendix F](#).

## Treatment

The treatment subcommittee was developed out of the need for addressing components of the plan directly related to treatment services and Medicaid, along with private insurance. The treatment subcommittee focused on reviewing current state processes and improving available engagement and treatment options to adapt to the increased need. The subcommittee consisted of researchers, behavioral health treatment providers, and subject matter experts to inform the recommendations below. The subcommittee was able to address ideas and develop recommendations that met various requirements outlined in Section 3. These recommendations meet the following statutory requirements in [RCW 71.24.546](#): (§3.a), (§3.b), (§3.c), (§3.d), and (§3.e).

(1) (3) The plan must consider:

(a) The points of intersection that persons with substance use disorder have with the health care, behavioral health, criminal, civil legal, and child welfare systems as well as the various locations in which persons with untreated substance use disorder congregate, including homeless encampments, motels, and casinos;

(b) New community-based care access points, including crisis stabilization services and the safe station model in partnership with fire departments;

(c) Current regional capacity for substance use disorder assessments, including capacity for persons with co-occurring substance use disorders and mental health conditions, each of the American society of addiction medicine levels of care, and recovery support services;


(d) Barriers to accessing the existing behavioral health system and recovery support services for persons with untreated substance use disorder, especially indigent youth and adult populations, persons with co-occurring substance use disorders and mental health conditions, and populations chronically exposed to criminal legal system responses, and possible innovations that could improve the quality and accessibility of care for those populations;

(e) Evidence-based, research-based, and promising treatment and recovery services appropriate for target populations, including persons with co-occurring substance use disorders and mental health conditions;”

Below are the recommendations and outlined plans of action developed from the treatment subcommittee and approved by the SURSA Committee.

### SURSA Committee recommendations

Recommendation 7: Health engagement hubs for people who use drugs



Health Engagement Hubs serve as an all-in-one location where people who use drugs can access a range of medical, harm reduction, treatment, and social services. Developing Health Engagement Hubs for people who use drugs considers and supports several plan elements, including points of intersection that persons with substance use disorder have with the health care system (RCW 71.24.546§3.a), locations in which persons with untreated substance use disorder congregate (ibid), new community-based care access points (RCW 71.24.546§3.b), and barriers to accessing the existing behavioral health system (RCW 71.24.546§3.d). This recommendation draws most immediately from a State Opioid and Overdose Response Plan (SOORP) Goal 2.2.1 and expands upon work from the Center for Community-Engaged Drug Education, Epidemiology and Research (CEDEER) at the UW Addictions, Drug, & Alcohol Institute, including low barrier buprenorphine programs and expressed needs/interests from program participants at Syringe Services Programs (SSP).

The subcommittee proposes Health Engagement Hubs to be affiliated with an existing SSP serving each community as well as other entities as appropriate, including federally qualified health centers (FQHCs)/community health centers (CHCs), patient centered medical homes, overdose prevention/safe consumption sites, peer run organizations (e.g., Club Houses), services for unhoused people, supportive housing, and opioid treatment programs. Harm reduction services and supplies must be an integral program component of any organization housing a health hub.

Services should address each of the care domains below, with as comprehensive a service mix as feasible:

- Comprehensive physical and behavioral health care
- Medical case management services/care coordination
- Harm reduction services and supplies
- Community health outreach workers/navigators, peers
- Linkage to housing, transportation, and other support services
- Spiritual Connection Communities

Health Engagement Hubs should encourage community volunteers, and provide appropriate training to staff and volunteers, including diversity, equity, and inclusion training. Services should be offered in coordination with every willing SSP.

Communities with a SSP may also offer services in other settings described above. Communities without a SSP may provide services in another setting given they institute a comprehensive harm reduction service and staffing continuum.

See [Appendix H](#).



## Recommendation 14: Safe supply workgroup

As part of the discussion surrounding the criminal legal response to possession of a controlled substance, the SURSA Committee identified safe supply as a necessary component to address diversion by providing safe resources for people who can benefit from this type of harm reduction service. The treatment subcommittee recommends assembling a statewide workgroup to make recommendations on a framework for safe supply for future inclusion in the Washington State Substance Use Recovery Services Plan. The workgroup would detail how the state may provide a regulated, tested supply of controlled substances to individuals at risk of drug overdoses. The workgroup should center the voices of people who use drugs, with lived and living experience, and who have lost loved ones. This workgroup should consider values of non-commercialization and alternative lawful income source for people who have been trapped in the illicit distribution economy and could be displaced by a safe supply program, to prevent potential unintended consequences that would disadvantage communities most impacted.

The recommendation meets individuals at points of intersection that persons with substance use disorder have with the health care system and locations in which persons with untreated substance use disorder congregate (RCW 71.24.546§3.a). It also addresses barriers to accessing the existing behavioral health system and recovery support services for persons who use drugs and/or with untreated substance use disorder, and possible innovations that could improve the quality and accessibility of care for those populations (RCW 71.24.546§3.d) by using evidence-based, research-based, and promising treatment and recovery services appropriate for priority populations, including persons with co-occurring substance use disorders and mental health conditions (RCW 71.24.546§3.e).

See [Appendix O](#).

## Recommendation 11: SUD engagement and measurement process

The recommendation that follows covers the component of the plan focused on low-barrier, person-centered care which should be informed by people with lived and living experience. This recommendation asks that:

- HCA convene a workgroup that will review current processes and workforce needs related to intake, screening, and assessment for substance use disorder (SUD) services
- HCA determine how to build an SUD engagement and measurement process, including developing any necessary rules and payment mechanisms

- HCA work with people who use drugs (PWUD), care providers, state regulators, and payors to address this recommendation within 12 months
- In the interim, any work that HCA can undertake to advance these goals should be done

Because SUD is chronic and potentially acutely life-threatening:



Care for people with SUD needs to be accessible and initiated as quickly as possible.



Care for people with SUD needs to be accessible in places and care settings that are low-barrier/crisis-oriented (e.g., Health Hubs for people who use drugs (PWUD), emergency departments, CHC/FQHC) in addition to care settings such as withdrawal management and specialty SUD treatment.



The initial engagement and measurement process should be focused on what is minimally necessary to document a diagnose, determine medical necessity and start care the same day, and be conducted in less than 15 minutes.



Initial engagement and SUD measurement must be focused on, and limited to, client's needs and should be limited to only the necessary domains. Trauma and culturally informed approaches must be taken in terms of the total time, content, and process of engagement and measurement.

Initial engagement should be person centered and address the needs expressed by the person seeking services. Current evaluations focus on complete and lengthy assessments designed to determine the severity of a person's substance use disorder and the type of treatment setting best designed to meet their needs. Recognizing not everyone will be ready for or interested in traditional treatment at the time of engagement, Initial assessments should center on understanding and meeting the persons self-identified needs, for example, food, shelter, harm reduction supplies, recovery supports information or same day treatment if available, in the order that best suits them. This approach also helps to build trust.

Access to timely SUD assessments varies widely across Washington State. In urban areas, people seeking or needing an assessment may go to drop-in hours multiple times over several weeks before they obtain an assessment. In rural areas there may be a single provider currently allowed to do assessments and they may have a multi-week wait list. Alternatively, in some care settings all that is needed to initiate care is an SUD diagnosis (e.g., a medical clinic with a licensed prescribing provider onsite). The

variable access to care by geography, provider types, and care settings is an example of state and federal rules and regulations negatively impacting equitable access to care.

See [Appendix L](#).


### Recommendation 15: Expanding funding for OTPs to include partnerships with rural

The recommendation proposes expanding funding for opioid treatment programs (OTP), to include mobile OTPs, into rural areas. As of September 1, 2022, there are 32 OTPs in Washington State, each serving between 200 to more than 1,000 patients. There is no federal rule limiting the number of individuals an OTP can serve, but state law in RCW [71.24.590](#)(2) does allow counties to set patient census limits (i.e., maximum capacity for a program). OTPs in Washington State collectively serve more than 14,000 people with a primary OUD diagnosis.

This recommendation establishes new community-based care access points (RCW 71.24.546§3.b), expands regional capacity for treatment via opioid treatment programs (RCW 71.24.546§3.c), and removes geographic barriers to accessing OTPs (RCW 71.24.546§3.d). Additionally, this recommendation aligns with the State Opioid and Overdose Response Plan (SOORP) Strategy 2, establishing access to the full continuum of care for person with opioid use disorder and Strategy 3, support and increase capacity of opioid treatment programs.

Access to opioid treatment program (OTP) services in rural areas recommendation includes:

- ❖ Encourage the Department of Health’s Health Services Quality Assurance (HSQA) division to create a regulatory workshop with OTP provider stakeholders in 2023 to:
  - Create state rules/regulatory process for OTP that want to establish offsite medication units (1) located as a free-standing facility; (2) co-located within in a variety of community settings such as but not limited to hospitals/medical primary care systems/pharmacies/FQHCs, as well as correctional health settings, etc.
- ❖ Change RCW [36.70A.200](#) and WAC [365-196-550](#) to ensure that OTP branch sites of all kinds (including mobile, and fixed, site medication units) are clearly seen as “essential public facilities” and that they cannot be zoned out or stalled by moratoriums by city and/or county legislative authorities.

- 
- ❖ Update RCW [71.24.590](#) to remove several requirements for the siting of opioid treatment programs that stigmatize the treatment setting type and subject these treatment centers to a higher burden of regulations than other behavioral health treatment settings.
  - ❖ Funding for capital construction costs to help start up OTP in Central and Eastern Washington.
  - ❖ Funding to a state agency such as HCA for established OTPs in Washington State to operate an increased number of OTP medication units in order to expand their geographic reach.

See [Appendix P](#).

## Recovery support services

As one of the first subcommittees generated from the SURSA Committee, the recovery support services subcommittee was tasked with further developing recommendations which populated out of the preliminary SURSA Committee meetings. The subcommittee was able to address these initial ideas and develop more recommendations that met the various requirements outlined in Section 3 of RCW 71.24.546. The recommendations below meet statutory requirements: (§3.a), (§3.b), (§3.c), (§3.d), and (§3.e).

(1) (3) The plan must consider:

- (a) The points of intersection that persons with substance use disorder have with the health care, behavioral health, criminal, civil legal, and child welfare systems as well as the various locations in which persons with untreated substance use disorder congregate, including homeless encampments, motels, and casinos;
- (b) New community-based care access points, including crisis stabilization services and the safe station model in partnership with fire departments;
- (c) Current regional capacity for substance use disorder assessments, including capacity for persons with co-occurring substance use disorders and mental health conditions, each of the American society of addiction medicine levels of care, and recovery support services;
- (d) Barriers to accessing the existing behavioral health system and recovery support services for persons with untreated substance use disorder, especially indigent youth and adult populations, persons with co-occurring substance use disorders and mental health conditions, and populations chronically exposed to criminal legal system responses, and possible innovations that could improve the quality and accessibility of care for those populations;
- (e) Evidence-based, research-based, and promising treatment and recovery services appropriate for target populations, including persons with co-occurring substance use disorders and mental health conditions;”

Below are the recommendations and outlined plans of action developed from this subcommittee and approved by the SURSA Committee.

## SURSA Committee recommendations

## Recommendation 1: Legislative policy for tax incentives and housing vouchers for

This recommendation stemmed from the need to continue recovery residential operations that offer MOUD services along with providing more housing options in all areas of Washington. The recommendation attempts to provide a strategy to mitigate the current housing market. The 2022 housing market consists of homeowners and recovery residences operators/owners finding it to be more profitable to sell their homes rather than continue to operate. The cost of real estate is working against the community and supportive system for those who are seeking recovery services. Operators are shifting out of recovery housing and selling their homes to capitalize on the current market.



The recommendation also addresses an approach for providing respite spaces for individuals who return to use or are awaiting treatment services. Housing operators would provide these spaces or create new residences to meet these individual's needs.

The recommendation outlines strategies to mitigate current markets while creating new community care access point (§3.c), at points of intersect for individuals with SUD (§3.a), using evidence-based, research-based, and promising treatment and recovery services appropriate for target populations (§3.e).

The subcommittee proposes:

- ❖ A property tax break for landlords to incentivize leasing their rental homes to housing operators.
  - Amending [RCW 84.36.043: Nonprofit organization property used in providing emergency or transitional housing to low-income homeless persons or victims of domestic violence. \(wa.gov\)](#), to include recovery residences under the exemption that currently only provides opportunities to transitional homes that house people for two years or less.
- ❖ A new voucher program would be ideal for experienced and accredited housing operators to hold bedspace for individuals who are awaiting appropriate treatment or who have returned to use and need a place to stay while negotiating a return to stable housing.



ESB 5476 established housing grants provided by the Department of Commerce in conjunction with the Health Care Authority. To receive this funding, housing providers must meet national standards and accreditation of the Washington Alliance for Quality Recovery Residences (WAQRR). Tribes are currently establishing relationships with WAQRR to further expand housing options. The grant funding provided previously should continue and give priority to tribes and rural areas for these grants.

See [Appendix B](#).

### Recommendation 3: LGBTQIA+ community housing

The Health Care Authority and Department of Commerce should be intentional when it comes to housing equity and inclusivity, and to the safety of LGBTQIA+ community members. This recommendation addresses current disparities regarding this population while drawing from intersections of people with substance use disorder (§3.a), addresses barriers to accessing the existing behavioral health system and recovery support services (§3.d), creates new community care access points (§3.c) by using evidence-based, research-based, and promising treatment and recovery services appropriate for target populations, including persons with co-occurring substance use disorders and mental health conditions (§3.e). Currently, housing providers have several individuals who apply and are accepted into housing that identify with the LGBTQIA+ community, but there are no supportive policies or training for operators to care for this population in a profound way.

Housing policy should be inclusive of LGBTQIA+ through state funded training for housing providers and drug courts on how to service this community in an informed and appropriate manner.

- ❖ Harassment training
- ❖ Communication
- ❖ Antiracism training
- ❖ Gender affirming/diversity training
- ❖ Cultural competency training

A low-barrier grant program where funding is contingent on implementing inclusionary policies operated through the Department of Commerce geared at recovery-based housing in underserved and rural areas for priority populations. To provide appropriate staffing, and operational considerations, housing operators and managers could identify agencies already working with the LGBTQIA+ community to help then design inclusive practices and policies. Smaller organizations/programs that

are more experienced in this area could also be utilized to create focused funding sources to established housing programs along with adding funds for newer programs or smaller organizations to also get a chance to establish these housing programs that may be more experienced in this realm. These grants can be focused on youth and rural areas along with establishing long-term funding that is sustainable, including capital funding and operational funds.

See [Appendix D](#).

#### Recommendation 4: Training of foster, kinship and family of origin, parents with children who use substances



Numerous gaps exist in services for foster care children. The recommendation requests to provide and enhance substance use training and recovery support education, creating a supportive environment for children and transition age youth (TAY), for foster and kinship guardians, and caregivers of displaced youth. Whenever possible, training and resources should also include family of

origin, to support chances of reunification and continued recovery and support upon return home. This recommendation provides a new intersection for people with substance use disorder (§3.a), addresses barriers to accessing the existing behavioral health system and recovery support services (§3.d), and creates a new community care access point (§3.c) by using evidence-based, research-based, and promising treatment and recovery services appropriate for target populations, including persons with co-occurring substance use disorders and mental health conditions (§3.e).

This recommendation would be promoted by applying supportive policy to obtain and provide naloxone to case workers, family of origin, foster/kinship families, and young people who use substances. This would include training around administering naloxone and identifying overdoses and addressing stigma through the provisions of a public education campaign and easily accessible resources.

See [Appendix E](#).

## Recommendation 16: Addressing zoning issues regarding behavioral health services

This recommendation addresses outdated language regarding recovery residence licensing and zoning barriers affecting treatment, harm reduction, and recovery services, as well as the inconsistency between state, county, and city/town regulations regarding zoning for these types of facilities. Addressing outdated language regarding recovery house licensing and zoning barriers affecting treatment, harm reduction, and recovery support services helps reduce barriers to accessing the existing behavioral health system and recovery support services (§3.d) and creates new community care access point (§3.c). Additionally, this recommendation aligns with [State Opioid and Overdose Response Plan](#) (SOORP) Goal 5, strategy 2, increasing and improving access to recovery housing.

Currently, [WAC 365-196-550](#) defines the types of public facilities considered essential when it comes to community development regulations. The processes that a city or county would use to identify and site these essential public facilities are outlined in [RCW 36.70A.200](#). Current RCW language lists 'inpatient facilities, including substance "abuse" facilities, mental health facilities, group homes, and secure community transition facilities' as essential. It is left to the discretion of the city and county to identify and site these locations within their areas.

Oftentimes, cities and counties are not provided adequate services due to the lack of appropriate identification and a clear description of the variety of services that are needed to address the substance use, mental health, and co-occurring population. The language should be updated to include inpatient, outpatient, recovery residences, harm reduction services (including SSP), community-based and treatment related programs, including OTPs and mobile treatment services. Furthermore, there should be consistency, regardless of demographics, for forcing cities and counties to provide the maximum number of services within their regions.

Recovery residences are not currently defined or referenced when it comes to licensing and zoning purposes. A definition should be established and used that reflects what a recovery residence provides, such as:

*Recovery housing benefits individuals in recovery by reinforcing a substance-free lifestyle and providing direct connections to other peers in recovery, mutual support groups and recovery support services. Substance-free does not prohibit prescribed medications taken as directed by a licensed prescriber, such as pharmacotherapies specifically approved by the Food and Drug Administration (FDA) for treatment of opioid use disorder as well as other medications with FDA-approved indications for the treatment of co-occurring disorder.*

To help facilitate the changes to zoning regulations, municipal and county officials would benefit from orientation to the services recommended to be sited in their jurisdictions. When given adequate information and statistical data, officials would be better able to make informed changes to address the current substance use crisis. Educational campaigns should be provided to cities, counties, and communities to provide information regarding the services that may be sited in their areas. Stigma and misunderstanding can cause resistance that could hinder the expansion of vital services.

See [Appendix Q](#).

### Recommendation 2: Legal advocacy for those affected by SUD

Legal advocacy should be provided for parents and families, including kinship and foster care families, that are affected by SUD in court cases regarding custody, parenting plans, guardianship, and Child Protective Services (CPS) cases. The following recommendation outlines various strategies on addressing this area of need.

There are no existing laws that allow for representation of parents and or guardians involved in parenting plan and dissolution cases. This recommendation calls for representation in family law cases, to those affected by substance use disorders, mental health, and behavioral health concerns. Family Law could adopt similar language and right to counsel in the Chapter 26.12 RCW series as they have in Chapter 13.34. Currently the only families provided services in family law case are American Indian/Alaska Native parents and children under [RCW 13.38.110: Right to Counsel](#). This recommendation proposes updating language in [RCW 13.34.030](#), the definition of indigent (b) to read: *Individuals in need of or receiving mental health, substance use, or behavioral health services.*

The Washington State Office of Public Defense currently serves all counties for those deemed indigent but additional services should be provided to assist therapeutic courts such as the Family Treatment Court (FTC) to provide counsel and services to families affected by SUD. Currently only 19 out of the 39 counties have an FTC or juvenile/family court program. Providing legislative requirements for dependency cases with those affected by substance use disorders, mental health, and behavioral health would require counties to utilize OPD and FTCs across the state.

Alternative solutions include providing clinics with court staff or experienced paralegals, connecting with community partners and peer navigators to include those

who navigate marginalized groups, to help parents navigate how to properly create parenting plans and to teach individuals how to navigate family law or dependency matters. Providing support for changes to parenting or reinstatement cases which have reunification as the goal, keeps families together and allows children to have rights to both their parents.

See [Appendix C](#).

### Recommendation 8: Employment and education pathways

The recommendation creates a grant program to build and sustain community-based behavioral health providers. The grant would expand availability of these types of programs with a low-barrier, one-page grant application, targeted for programs that engage with BIPOC and other historically underserved

communities. There could also be individual grants or a scholarship-type program for people in recovery housing that in addition to job training would provide for childcare expenses,, drivers licensing testing fees, transportation, along with any costs associated with r the job training itself.

Regional and county-wide programs have been made available to individuals who are seeking employment, education, training/certification, and other supportive resources. Additionally, there are programs provided for incarcerated individuals to seek and obtain employment upon release. In King County programs like Road Map to Success, Orion Industries, and Post Prison Education Program have assisted people in city, county, and tribal jails, as well as the Washington State Department of Corrections. These programs include, welding certification, entrepreneurship, construction-related work, and Commercial Driver Licenses, to name a few. Though there are varied programs available to those with SUD, in recovery, incarcerated, or being released from incarceration, there are still barriers. This recommendation would work in conjunction with current measures outlined in the [State Opioid and Overdose](#)



[Response Plan](#) (SOORP) Goal 5, Strategy 1, increasing and improving access to employment services for individuals in recovery, along with current state programs that provide education and employment pathways.

In less dense areas, there are few resources and an all-around barrier to receiving a livable wage. The stigma of substance use is also a barrier, making it difficult to obtain employment. Programs like peer support and 0-1 intercept interventions should also connect these individuals to needed resources. This recommendation includes expanding efforts for incorporating incarcerated individuals and recently released from incarceration into resources available through these programs.

See [Appendix I](#).

### Recommendation 18: Continuum of housing

The SURSA Committee asks the state to provide capital and operating funding to support housing options at various points of intersection along the continuum of care, to include housing people who use drugs, to those who are in recovery, which may or may not include abstinence. This includes a request for funding to support immediate shelter options to bridge or transitional housing through long-term permanent housing. It is urgent that the Legislature fund a continuum of housing and housing services for individuals who use drugs, and those who are abstinent, through capital and operating investments.

This recommendation meets several considerations for the Substance Use Recovery Services Plan including *RCW 71.24.546§3(a), 3(b), and 3(e)*.

The SURSA Committee acknowledges and encourages ongoing participation in, and collaboration with, initiatives, including but not limited to:

- Permanent Supportive Housing Advisory Committee, established per [HB 1724](#)
- Behavioral Health Housing Action Plan
- Washington State Health Care Authority
- Washington State Department of Health
- Washington State Department of Commerce
- Low Income Housing Institute
- The Washington Alliance for Quality Recovery Residences
- Oxford House
- Public Defender Association (PDA) CoLEAD/JustCARE
- Evergreen Treatment Services REACH Program



- Downtown Emergency Service Center
- Plymouth Housing
- Catholic Community Services

Continued participation and collaboration in this work should include supporting evidence-based and promising models and systems for consideration.

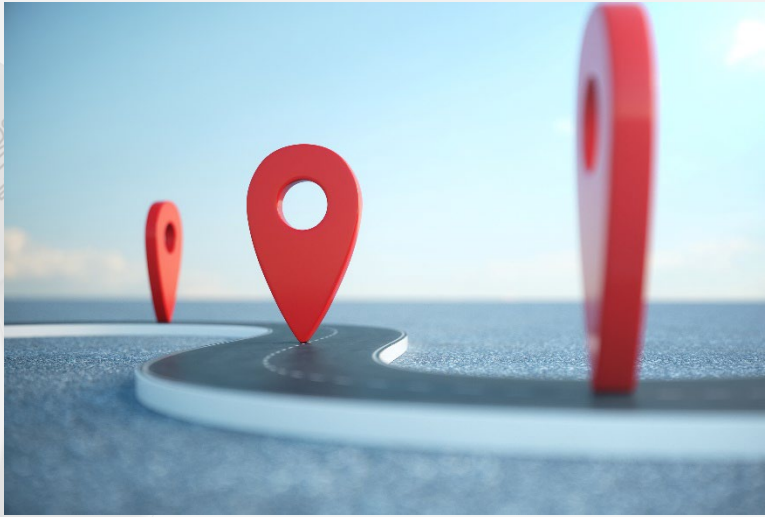
We recommend that the work is centered on people who use substances and/or experience mental health conditions who have lived/living experience with homelessness and/or housing instability, such as:

- Individuals who encountered barriers in the shelter and homeless housing systems due to active drug use or being in recovery from substance use disorder
- Individuals who used shelter and/or homeless housing systems while actively using drugs or working on their recovery
- Individuals with expertise designing and operating bridge housing or temporary lodging for people with high barriers including current drug use
- Individuals with expertise bridging systems and designing systems to meet the needs of historically under-served populations
- Individuals with knowledge of current state investments in homelessness response
- Individuals with knowledge of Trueblood Settlement Agreement housing investments
- Individuals with knowledge of Continuums of Care/Coordinated Entry in homeless housing

See [Appendix R](#).

Recommendation 9: Expansion of the Washington Recovery Helpline and asset

It is vital to provide a tool that maps and directs individuals to community-based care access points and helps locate and help those currently in need of outreach, treatment, and recovery support services. This helps achieve the requirements that intersect people with substance use disorder (§3.a) and address barriers to accessing the existing behavioral health system and recovery support services (§3.d). By expanding upon the current recovery readiness asset tool built from the Roadmap to Recovery and the Washington Recovery Helpline, we can enhance the capabilities of the tools available to reach more Washingtonians affected by SUD and their families.



This tool should also work in conjunction with the E2SHB 1477 work to designate a primary technology system to provide “real-time bed availability for all behavioral health bed types, including but not limited to crisis stabilization services, triage facilities, psychiatric inpatient, substance use disorder inpatient, withdrawal management, peer-run respite centers, and crisis

respite services, inclusive of both voluntary and involuntary beds, for use by crisis response workers, first responders, health care providers, emergency departments, and individuals in crisis.”

Campaigning and advertising for the Washington Recovery Helpline is necessary for educating the public on the helpline and tools, along with indicating its intent as opposed to a crisis hotline. Along with additional resources for a heartier system, the Washington Recovery Helpline will need full-time employees (FTEs) who are non-clinical and have lived experience, to support expansion of work on the database and to meet the growing demands. Substantial staffing will be needed to support a tool dynamically.

See [Appendix J](#).

## ESB 5476 program updates

### Recovery navigator program

RCW [71.24.546§3\(h\)](#): “The design of recovery navigator programs (RNPs) in RCW [71.24.115](#), including reporting requirements by behavioral health administrative services organizations to monitor the effectiveness of the programs and recommendations for program improvement.”

Each behavioral health administrative services organization (BH-ASO) has established a recovery navigator program. RNP is a pre-arrest diversion program which provides community-based outreach, intake, brief assessment, and connection to services and, as appropriate, long-term intensive case management and recovery coaching services, to youth and adults with substance use disorder, including for people with co-occurring substance use disorders and mental health conditions, who are referred to the program from diverse sources and shall facilitate and coordinate connections to a broad range of community resources for youth and adults with substance use disorder, including treatment and recovery support services.

*Table 6: Recovery Navigator Program Implementation by Region*

Region	Implementation
Thurston-Mason	January 2022
Salish Kitsap/Jefferson/Clallam Clallam (PBH)	December 2021 Feb/March 2022
Spokane Adams Pend Orielle/ Ferry/ Lincoln/Stevens/Spokane	February 2022 March 2022
King	April 2022
Pierce	November 2021
Great Rivers	March/April 2022
Southwest	December 2021
Greater Columbia	March 2022
North Sound	Feb/March 2022
North Central Okanogan Chelan/Douglas/Grant	December 2021 April 2022

Peer-Run and clubhouse services expansion

HCA Clubhouse Peer Run Program received additional funding from State v. Blake with the primary focus of expanding peer services to areas lacking programming to address substance use disorder throughout Washington State. HCA achieved its goal, providing

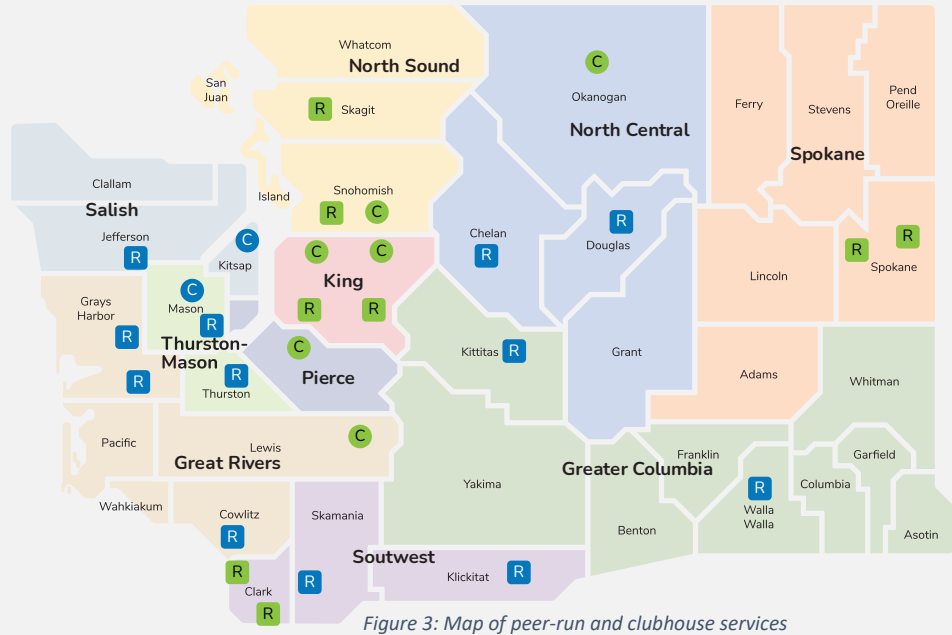


Figure 3: Map of peer-run and clubhouse services

funding to an additional 11 peer run agencies. Per legislative directive, the program was able to extend to into rural and Eastern Washington, including Chelan, Grays Harbor, Cowlitz, Kittitas, Skamania, and Klickitat counties. There are innovative expansion efforts by providers, including pop-up locations in frontier communities and specific program services for marginalized and underserved populations. Recovery Café of Clark County utilized the funding to establish three Pop-up Cafes currently operating in Washougal, Stevenson, and Goldendale. Peer WA Olympia has expanded services to rural areas by removing transportation barriers for access to services at their Olympia location from Grays Harbor, Lewis, and Mason counties. The Moore Wright Group opened a new Recovery Café in Aberdeen offering recovery support and innovative online and in-person workforce development training.

Chai Rivers Recovery Café located rural Kelso in Cowlitz County, opened its doors in a remote area lacking recovery programming. Caring with Compassion Community joined as an HCA provider offering services for BIPOC, marginalized communities in Graham in Pierce County. REBOOT Recovery helps veterans, first responders and all families heal from trauma addressing the mental health and suicide epidemic through peer-led services. Trilogy Recovery Center is engaging youth, adults and families impacted by justice involvement with peer services.

Homeless outreach stabilization transition (HOST) expansion

HCA has expanded homeless outreach stabilization transition (HOST) programs with the goal of expanding access to modified assertive community treatment delivered by multi-disciplinary teams. HCA has contracted with North Sound BH-ASO, King BH-

ASO, Thurston Mason BH-ASO, Beacon Health Options, and Spokane BH-ASO to implement HOST teams in Snohomish, King, Pierce, Thurston, Clark, and Spokane counties. The teams perform outreach and engagement to individuals who are living with SUD and are experiencing lack of, or transitioning from, housing. HCA is also contracting with Downtown Emergency Services Center (DESC) to provide consultation and technical assistance on delivering this services model, and establishing guidelines regarding team staffing types, service intensity, quality fidelity standards, and metrics to verify programs are targeting the priority population.

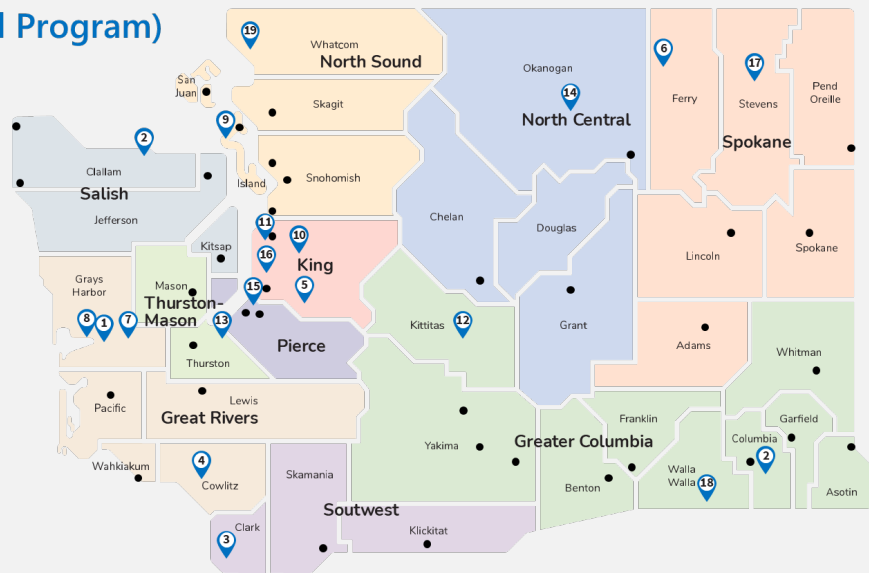
Medication for opioid use disorder (MOUD) in jail

### Medications for Opioid Use Disorder (MOUD in Jail Program)

● County, City or Tribal Facility

1. Aberdeen City Jail
2. Clallam County Jail
3. Clark County Jail
4. Cowlitz County Jail
5. Enumclaw City Jail
6. Ferry County Jail
7. Grays Harbor County Jail
8. Hoquiam City or Jail
9. Island County Jail
10. Issaquah City Jail
11. King County Jail
12. Kittitas County Jail
13. Nisqually Tribal Jail
14. Okanogan County Jail
15. Pierce County Jail
16. SCORE – South Correctional Entity
17. Stevens County Jail
18. Walla Walla County Jail
19. Whatcom County

● Location not participating



Through a combination of funding in ESB 5476 and ESSB 5092, HCA contracts with local jails to ensure they meet the medication-based need of individuals with opioid use disorder. HCA has finalized contracts with 19 separate city, county, and tribal jails and using the funding to provide seamless access to medications for opioid use disorder (MOUD). These MOUD in jails programs provide incarcerated individuals the opportunity for an OUD assessment, evidence-based medication for OUD, sustained treatment throughout incarceration, and connection to continue treatment upon release or transfer. Overall benefits may include reduction in morbidity and mortality due to overdose, reduced re-offenses, reduced complications during withdrawal, improved jail staff safety, cost savings, reduced transfers to emergency departments, custodial costs, and overall improved relationships.

### Contingency management

According to RCW 71.24.145 (3), "Subject to the availability of amounts appropriated for this specific purpose, the authority shall increase contingency management resources for opioid treatment networks that are serving people living with co-occurring stimulant use and opioid use disorder."

Contingency management is an evidence-based behavioral intervention for stimulant use disorder. It provides incentives to individuals contingent upon objective evidence of the target behavior, such as a negative urine drug test, to increase the likelihood of these behaviors, which are essential components and outcomes of effective treatment. Funding for contingency management was included in ESB 5476. Program managers developed a contingency management intervention in the Opioid Treatment Networks and Hub and Spokes. The State Hub and Spoke project completed their contingency management trainings in September 2021 and are working with WSU PRISM staff to implement their programs and engage in fidelity monitoring.

### Short-term housing vouchers

Through appropriations in ESB 5476, HCA provided short-term housing vouchers for people with substance use disorders. These housing vouchers were provided through existing contracts with Housing and Recovery through Peer Services (HARPS) providers and were used to support individuals who required short-term or transitional housing and had a substance use disorder.

### Substance use disorder (SUD) family navigators

The substance use disorder (SUD) family navigator project focuses on implementing navigators who can serve families and individuals of loved ones experiencing SUD. This program was expanded to three new sites that support parents, partners, and other adult family members of youth and young adults experiencing SUD-related challenges navigating systems of care. Services to adult family members are provided by trained and certified family-support peers and include one-to-one peer coaching, socialization, peer group support, education groups, employment support, supportive housing, and referrals. The SUD navigators are trained to provide developmentally appropriate services to individuals and families and assist them with navigating the system in support of their loved one.



## Conclusion

### Next steps

ESB 5476 outlines the next steps for the Authority to take regarding the plan. The language states:

*“After submitting the plan, the authority shall adopt rules and enter into contracts with providers to implement the plan by December 1, 2023.”*

To fulfill the bill requirements, HCA will prioritize implementing accessible policies and contracts. Currently, there are no dedicated funds to immediately implement new programs. HCA will work in collaboration with current efforts that intersect the criminal legal system and behavioral health systems to connect the components proposed in the plan. The SURSA Committee will continue to meet quarterly to be provided updates and review the quarterly reports from the Recovery Navigator Program.

### Constraints and limitations

The SURSA Committee has specified early on the need for more meaningful approaches to the plan and the recommendations. Though [RCW 71.24.546](#) required that the SURSA Committee include people with lived experience, it was clear that there was need for additional, dedicated space solely for individuals with lived or living experience to participate. HCA will continue to include the community and underrepresented populations in ongoing work around the SURSA Committee and SURS Plan.

The time constraints surrounding the plan and development were very limited, leaving little to no opportunities to seek community and subject matter expertise outside of the SURSA Committee membership within the two-hour monthly meetings. This is what ultimately led to the creation of the subcommittees and the openness of those groups. Time continued to be a barrier within the plan development, leading to unmet bill requirements.

One recommendation was deferred to be addressed at a later date. Unfortunately, time was limited to attempt to address and adjust the recommendation brought forth by the Outreach, Engagement, and Diversion subcommittee. This recommendation requests an amendment to the Good Samaritan law for administering life-saving medications to prevent death from an overdose.

See [Appendix U](#).

## Unmet bill requirements

- *(f) Options for leveraging existing integrated managed care, medicaid waiver, American Indian or Alaska Native fee-for-service behavioral health benefits, and private insurance service capacity for substance use disorders, including but not limited to coordination with managed care organizations, behavioral health administrative services organizations, the Washington health benefit exchange, accountable communities of health, and the office of the insurance commissioner.*
  - HCA acknowledges that existing committees, such as the Behavioral Health System Coordination Committee, enacted in [RCW 71.24.861](#), meets the legislative intent above. For that reason, and others, priority was given to recommendations by subcommittee chairs based on the anticipated impacts in communities.
  
- *(j) Strategic grant making to community organizations to promote public understanding and eradicate stigma and prejudice against persons with substance use disorder by promoting hope, empathy, and recovery.*
  - ESB 5476 did not include proviso funding to support development and implementation strategy for a strategic grant program. The SURSA Committee prioritized other immediate, achievable recommendations, and could address any future efforts if funding were made available in subsequent biennia.

## Appendices

### Appendix A – Timeline

*Table 9: Committee and subcommittee meeting dates*

SUSRAC	Treatment	RSS	Data	OED	Deadlines
January 3					
February 7					
March 7		March 9 and 23			
April 4		April 6 and 20	April 27	April 26	
May 2	May 3, 17 and 31	May 4 and 18	May 25	May 10 and 24	
June 6	June 14 and 28	June 1, 15 and 29	June 8 and 22	June 7 and 21	
July 11	July 12 and 26	July 13 and 27	July 6 and 20	July 5 and 19	
August 1	August 9 and 23	August 10 and 24	August 3, 17, and 31	August 2, 16, and 30	
September 12	September 6 and 20	September 7 and 21	September 14 and 28	September 13 and 27	
October 3	October 4	October 5	October 11	October 13	October 11– Final Recommendations
November 7					
December 5					December 1 – Plan Submission to LEG

Appendix B – Recommendation 1: Legislative policy for tax incentives and housing vouchers for respite spaces

**Recommendation** – Legislative policy recommendation for replicating and enhancing “good work”, tax incentives for recovery housing services, and housing vouchers for those homes.

*Bill requirement: Section 1(3)(c), (d), (e)*

**Synopsis** – The suggestion was made for helping private locations with state or funding support such as capital funding to help establish recovery residences. HCA shared that a potential capital loan program that may be coming up later in the year or next year specifically for recovery residences. New recovery residence operating funds will be open for competitive application by mid-May, more details to come as this opportunity becomes available. There are a few factors that can hinder growth in this area including the overall cost of housing. The cost of real estate is working against the community. Some people are getting out of recovery housing and selling their houses to capitalize on the current market.

- ❖ The Legislature works with a lot of housing programs. A property tax break for landlords to incentivize leasing their rental homes to housing operators.
- ❖ Incentivizing HUD owned homes to turn into recovery residences and matching homes with recovery residence operators.
- ❖ Low-Income Housing Institute invest in those who already own or want to invest in, or start programing, they can help manage different programs. <https://lihi.org/>
- ❖ Local jurisdictions sometimes sell properties to use for low-income housing. If this can happen in an organized manner to increase the number of recovery residences, these homes would need to be matched with recovery residence operators.
- ❖ Rural communities could work together in partnerships with HCA staff to assess local needs and seek funding to expand recovery residence capacity.
- ❖ Currently there are a limited number of categories for property tax exemption. An operator can qualify for a property tax break for emergency transitional housing, where the operator can apply and the landlord benefits from exemption. To qualify, an operator must enforce a cap on resident stay which is currently 2 years. This recommendation would be to add a specific category to the exemption list to include accredited recovery residences.
  - [WAC 458-16-165:](#)
  - [RCW 84.36.043: Nonprofit organization property used in providing emergency or transitional housing to low-income homeless persons or victims of domestic violence. \(wa.gov\)](#)
  - [WAC 458-16-320:](#)

**Plan of Action:**

- ❖ A new voucher program would be ideal for experienced and accredited housing operators to hold bedspace for individuals who are awaiting appropriate treatment or who have returned to use and need a place to stay while negotiating a return to stable housing.
  - Temporary secure housing would fill the large gap in the continuum of care for individuals seeking appropriate treatment—many are overlooked and are left without treatment.
  - A weekly voucher should be made available to hold a bed in a staffed and accredited recovery residence for those who are awaiting treatment or return to use. Vouchers

should be used to support these dedicated spaces whether the beds are filled or not (Some Drug Courts currently fund spaces for participants whether the beds are filled or not.)

- Creating a more rapid response by providing respite spaces to be made available in a recovery residence for those who return to use, don't qualify for detox, or seeking treatment and need a safe place to stay by creating a new or existing arrangement for operators for short term stays with quick turnaround times.
- ❖ Different types of facilities receive property tax breaks. Recovery residences could be added to the list in the RCWs. Exemptions are currently only allowed for transitional homes that house people for two years or less. A change in the current law would provide a property tax exemption for residences that do not limit residents' length of stay. The exemption could be claimed by a homeowner whether they operate a recovery residence themselves or rent to an accredited operator.
- ❖ Continuing and expanding the COM/HCA housing grants provided out of 5476.
- ❖ Subcontracted training that providers can go through, by HCA, from people that meet national standards (WAQRR) then they would be eligible and accredited.

**Financial Impact:**

Dollars	FY23	FY24	FY25
<b>5476 Funding</b>	\$200,000/Housing Vouchers 525,000/Housing Grants	\$200,000/Housing Vouchers 525,000/Housing Grants	\$200,000/Housing Vouchers 525,000/Housing Grants
<b>Grant Funding</b>	Grants (Commerce currently is offering \$1,000,000 in housing expansion grants for fiscal year 2022-23.		
<b>Total Funds</b>			
<b>Staff (FTE)</b>	0	0	0

**Consideration of youth, rural areas, and tribes:**

Youth:

Additional programs will be brought up specifically for youth in this realm later.

Rural Areas:

5476 can support communities to provide regional specific recommendations to develop a response that works for them. Incentivizing with policies but to also enforce the same policies in rural areas. Giving priority to tribes and rural areas for the continuation of grants.

Tribes:

Tribes are having conversations with WAQRR. Oxford has a few housings on tribal lands and off the reservation specific to tribes. Tribes will retain their rights to select their providers that they work with. Giving priority to tribes and rural areas for the continuation of grants.

**Collaboration/Existing Programs:**

*5476 provided 7 grants of \$75,000 to recovery residences in 2021-22 and will make \$1,000,000 in grants in 2022-23.*

**SURSA Committee feedback**

No feedback on the content of the recommendation was provided from SURSAC members during the pre-meeting review period.



## Appendix C – Recommendation 2: Legal advocacy for those affected by SUD

**Recommendation** – *Legal Advocacy for parents and families, including kinship and foster care families, that are affected by SUD in court cases regarding custody, parenting plans, guardianship, and CPS cases.*

**Bill Requirement(s)** – *5476 Section 1.3 (a), Section 4.3(f)and(i)*

### **Background and Supporting Data:**

When an individual enters the criminal legal system, there are a number of granted resources made available but when it comes to family court there are very limited resources. There are resources currently available including the Office of Public Defense Parents Representation Program, [The First Clinic](#) , and [Family Treatment Court](#).

### **Dependency Cases:**

*Proposal of updating language in [RCW 13.34.030](#), definition of indigent (b) to read:*

*Individuals in need of or receiving mental health, substance use, or behavioral health services.*

Updating this language would modify [RCW 13.34.090](#), providing appointed counsel by the court for dependency and termination of parent-child relationship cases.

The Office of the Public Defenders currently serves all counties for those deemed indigent but additional services should be provided to assist therapeutic courts such as the Family Treatment Court to provide counsel and services to those families affected by SUD. Creating FTCs is possible, King County started by a federal SAMHSA grant and then scaled in size over the years with more sustainability grants and county funding. Counties without FTC could utilize this possible framework but would need to have numbers to support it, such as filing numbers, filings due to substance use disorder, etc. and scale a foundation based upon how big the FTC initially needs to be. 1/10th percent sales tax can then go towards supporting behavioral health treatment services, as well as sustaining an FTC. Family Treatment Courts are modeled after drug courts and veterans' courts, aiding parents in regaining control of their lives and promote long-term, stabilized recovery.

Currently only 19 out of the 39 counties have an FTC or juvenile/family court program of this nature. Providing legislative requirements for dependency cases with those affected by substance use disorders, mental health, and behavioral health would require counties to utilize OPD and FTCs across the state. Supplementing counties with contracts with programs such as [The First Clinic](#) to provide support until programs are established. Working with courts to providing clinics to help parents navigate how to properly navigate dependency matters.

Providing support for reunification cases to have reunification as the end goal or more access to children and visitation.

### **Family Court:**

There are no existing laws that allows for representation for parents and or guardians involved in parenting plan and dissolution cases. This recommendation calls for representation in family law cases, to those affected by substance use disorders, mental health, and behavioral health concerns.

This recommendation request asks for the Family Law Board to work in conjunction with the Office of the Public Defenders to provide legal representation for primary residential parent and nonprimary residential parents(noncustodial) in parenting plan and custodial cases. Family Law could adopt similar language and right to counsel in the Chapter 26.12 RCW series as they have in Chapter 13.34. Currently the only families provided this service in family law case are American Indian / Alaska Native parents and children under [RCW 13.38.110](#): Right to counsel.

Providing clinics to have court staff or experienced paralegals, connecting with community partners and peer navigators to include those who navigate marginalized groups, to help parents navigate how to properly create parenting plans and to teach individuals how to navigate the family law or dependency matters. Providing support for changing to parenting or reinstatement cases to have reunification as the end goal and the children to have rights to both their parents.

***There are situations which would require further analysis, such as one parent who does have SUD and another who does not, so what would be the determining factor(s) for representation?***

#### Concerns and Considerations –

- *Considerations should consider building recommendation in conjunction with housing and housing requirements. For example, there is nothing that states that a parent cannot live with their child in a car or RV, yet those facts often are used against them.*
- *There is a lot of system struggle with the treatment world, and it has been decimated because specialists are not given livable wages. Funding is primarily going into legal counsel and there needs to be some form of scale or rubric to determine monetary need for legal representation.*
- *At any given time, the OPD Parent Representation Program services roughly 9,000 parents and the program costs about \$26 million annually. Family Law would most likely be much bigger than this.*
- *A statement was made that further enriching courts would not help parents that need legal representation. A suggestion was made to look further into a decriminalization framework so that issues surrounding SUD do not get to become a legal issue for parents involved in FTC.*
- *Changing the definition of ‘indigent’ will also prove difficult and there was concern as to whether definition changes can be done via SURSAC work.*
  - o *There is currently another subcommittee looking at changes to the drug paraphernalia law. Additionally, the Blake Bill calls for legal advocacy and recovery support services.*
- *The point was made that it is crucial to be clear in the definition of ‘indigent’ and within legal language because family law and dependency involvement are different services.*
  - o *The recommendation will also need to expand upon the different services that would be allotted for family law and for dependency matters.*
  - o *The recommendation was created on the basis that there are services available to individuals who are CPS involved or who have dependency matters, however, there are no services for non-custodial parents that are not involved with these programs.*
- *Concern regarding the broadness of the definition of indigent, should be directed to those that demonstrate the need for representation.*

#### Collaboration with Existing Resources:

- *The Court Improvement Program of the state Administrative Office of the Courts was awarded a \$1.75 million grant to strengthen and expand the provision of Family Treatment Court (FTC) services in Washington. The grant was provided through the Department of Justice and integrated a coordinated*

**SUBSTANCE USE AND RECOVERY SERVICES PLAN**

*effort in partnership with the state Department of Children, Youth and Families (DCYF) and the state Health Care Authority (HCA) to assist those families affected by substance use disorders.*

**Approximate Financial Support and Staffing Needed:**

Dollars	FY23	FY24	FY25
<b>Legislative / State Budget Funding</b>	\$2.0 M / Expansion of FTC to all counties	\$3.75 M FTC Funding	\$3.75 M FTC Funding
<b>HCA Grant-Based Funding</b>			
<b>Total Funds</b>			
<b>Staff (FTE)</b>	0	0	0

**SURSA Committee feedback**

No feedback on this recommendation was provided from SURSAC members during the pre-meeting review period

Appendix D – Recommendation 3: LGBTQIA+ community housing

**Recommendation** –LGBTQIA+ housing options and *policy changes*.

*Bill requirement: Section 1(3)(a), (c), (d), (e)*

**Plan of Action:**

- ❖ Policy from Drug Court to identify individuals of the LGBTQIA+ community.
- ❖ Housing policy to be inclusive of LGBTQIA+
  - State funded training for housing providers on how to service this community in an informed and appropriate manner. A mandatory training annually for those who have direct contact with residents. This training should incorporate a multifaceted approach including:
    - Harassment Training
    - Communication
    - Antiracism training
    - Gender affirming/diversity training
    - Cultural competency training
 These models and training should be provided top down from the director and board to the staff.
  - Staff should also identify with the LGBTQIA+ community.
  - Incorporating community members to help inform the training and policies.

**Synopsis** – Housing providers have several individuals who apply and are accepted into housing that they identify with. At times, housing providers could also place individuals into single rooms for privacy purposes. This group must be intentional when it comes to housing, and to the safety of community members. Addressing LGBTQIA+ housing options requires more input and representation from the community. There is a lack of affordable housing or recovery housing in rural areas. Develop housing operator training that is culturally and linguistically inclusive and representative of this population.

- ❖ Organizations invited to participate in this discussion:
  - Trans Women of Color Solidarity Network
  - Utopia
  - Mockingbird Society – Keeping Kids in Kent
  - Lambert House in Seattle was given as an example of place that supports marginalized communities.
  - Disability Rights Washington
  - POCAAN
  - Asian Counseling Referral Services
  - Creative Justice
  - Lavender Rights Project
- ❖ A low-barrier grant program operated through Department of Commerce geared at recovery-based housing in underserved and rural areas for priority populations where funding is contingent on implementing inclusionary policies.

**SUBSTANCE USE AND RECOVERY SERVICES PLAN**

- Smaller organizations/programs that are more experienced in this area. Can utilize these groups to share the funding component to create focused funding sources to established housing programs along with adding funds for newer programs or smaller organizations to also get a chance to establish these housing programs that may be more experienced in this realm.
- Grants can be focused on youth and rural areas as part of this recommendation.
- ❖ Make sure that long term funding is sustainable, something like revolving funds for other recovery housing.
- ❖ Expand the definition of Fair housing and allow more people to be housing providers.

**Financial Impact:**

Dollars	FY23	FY24	FY25
<b>5476 Funding</b>	\$525,000/ Adult Housing Grants \$525,000/ Youth Housing Grants \$60,000/ Training	\$525,000/ Adult Housing Grants \$525,000/ Youth Housing Grants \$60,000/ Training	\$525,000/ Adult Housing Grants \$525,000/ Youth Housing Grants \$60,000/ Training
<b>Grant Funding</b>			
<b>Total Funds</b>	\$1,110,000	\$1,110,000	\$1,110,000
<b>Staff (FTE)</b>			

**Consideration of youth, rural areas, and tribes:**

Youth: Grants in this recommendation are not only focused on adult housing but also youth housing.

Rural Areas: Rural areas will be prioritized for providing these grants.

Marginalized Communities: This recommendation is specifically focused on marginalized communities in Washington that identify as part of the LGBTQIA+ community as well as focusing on rural areas and youth programs.

**Collaboration/Existing Programs:**

COM and HCA have existing housing grants through 5476, this recommendation would be an expansion of these grants to focus on the LGBTQIA+ community in Washington.

**SURSA Committee feedback**

No feedback on this recommendation was provided from SURSAC members during the pre-meeting review period

Appendix E – Recommendation 4: Training of foster and kinship parents with children who use substances

**Recommendation** –Funding for training of case workers and kinship caregivers/ foster parents with children with SUD. Along with providing equal resources to family of origin.

*Bill requirement: Section 1(3)(a), (c), (d), (e)*

**Synopsis** –

- Numerous gaps that can exist in services for foster care children.
- The recommendation to provide/enhance substance use and SUD training and recovery support education, creating a supportive environment (CRAFT model, or other EBP) for children and TAY for foster and kinship guardians, caregivers of displaced youth.
- There is a concern that young people who use substances are being criminalized.
- There is a lack of supportive services for youth seeking recovery.
- Would like to include kinship care in training, wrap around services, and other benefits that foster care families acquire.
- Would also include servicing transition age youth not only with SU concerns but mental health as well.
- Should include other organizations in the discussion aside from DCYF, Community Youth Services and A Way Home Washington were suggested, along with those with lived experiences.
- Would like to hear from foster families that may be able to share gaps in the system.

**Plan of Action:**

- ❖ Supportive policy to obtain and provide naloxone for case workers and foster/kinship families along with young people who use substances to be supplied naloxone. This would include training around administering naloxone and identifying overdoses.
  - Currently, DCYF has no formal policy around carrying and administering naloxone. DCYF is forming a workgroup to address the issue. DCYF has also consulted the Department of Health and reviewing trainings on naloxone.
- ❖ Provide/enhance SUD training and recovery support education, creating a supportive environment (CRAFT model, or other EBP) for children and Transition Age Youth (TAY) for foster and kinship guardians, caregivers of displaced youth. The [Safety First Curriculum](#) by Drug Policy Alliance is designed for high school aged youth. Foster families have to go through so many hours for training, policy change recognizing SUD, how to recognize and treat an overdose, and what is recovery with an option to have training in trauma informed approach and developing support groups.
- ❖ Providing parity for family of origin as well.
  - Incorporate behavioral health training, including suicide prevention.
- ❖ Including addressing stigma by public education campaign than actual messaging about naloxone itself.

**Financial Impact:**

Dollars	FY23	FY24	FY25
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**SUBSTANCE USE AND RECOVERY SERVICES PLAN**

<b>5476 Funding</b>	\$120,000 Training Development/Trainings \$1M Education Campaign \$1.2M Naloxone/ Foster-Kin-Case Managers *	\$40,000 Training \$1.2M Naloxone/ Foster-Kin-Case Managers *	\$40,000 Training \$1.2M Naloxone/ Foster-Kin-Case Managers *
<b>Grant Funding</b>			
<b>Total Funds</b>	\$2,320,000	\$1,240,000	\$1,240,000
<b>Staff (FTE)</b>			

\*Based on taking data from Data from the KIDS COUNT data center and from Adoption and Foster Care Analysis 2020 and providing kits for 20% of this population.

**Consideration of youth, rural areas, and tribes:**

Youth: This recommendation is focused on youth and foster/kinship individuals and families affected by SUD and drug use.

**SURSA Committee feedback**

No feedback on this recommendation was provided from SURSAC members during the pre-meeting review period



## Appendix F – Recommendation 5: Amend RCW 69.50, 4121 – Drug paraphernalia law

**Recommendation** – Amend [RCW 69.50.4121](#) to remove language that prohibits “giving” or “permitting to give” drug paraphernalia in any form, so that programs who serve people who use drugs do not risk class I civil infraction charges for providing life-saving supplies needed for comprehensive drug checking, safer smoking equipment, and other harm reduction supplies to engage and support people who use drugs. The state shall expressly preempt the field in Washington state regarding any penalties imposed for selling/giving paraphernalia per RCW 69.50.4121.

*Bill requirement: This amendment will support low barrier, person centered outreach and treatment services that improve safety for people who use drugs (Section 1.1); it also considers the points of intersection that persons with substance use disorder have with behavioral health systems and the places where persons with untreated substance use disorder congregate (Section 1.3(a)).*

Is this a contract request, state plan amendment, funding request, or legislative policy change?

Legislative Policy Change

### Synopsis

*Many SUD service programs, especially harm reduction programs, are experiencing significant barriers adapting to accommodate changing drug use patterns and unprecedented surge of deaths from overdose, and to engage equitably with all people who use drugs and in all manners of ways that people are using drugs. Much of this is in due to paraphernalia laws that prohibit the distribution of drug paraphernalia in any form. Amending this law would allow harm reduction programs to provide drug testing equipment, including but not limited to fentanyl test strips, and safer smoking equipment to engage and support people who use drugs without risk of incurring a class I civil infraction.*

*A significant service of harm reduction programs is to also connect people who use drugs with additional services that are aligned with their recovery. Therefore, it is essential that supplies that engage with people who use drugs in a variety of ways are allowed for distribution.*

*Recent reports suggest a drastic shift in drug use patterns in Washington State. Emerging research related to the changing West Coast drug supply, survey information from SSP participants in Washington collected by University of Washington researchers, and anecdotal information from Washington-based SSPs indicate that the ubiquity of fentanyl in the street drug supply is causing many people who inject drugs to transition to smoking fentanyl, primarily due to difficulties finding accessible veins<sup>6</sup> and their inability to find heroin. In addition, many people who use drugs report stimulant use, and most often report smoking as the primary mode of administration for drugs like methamphetamine.<sup>7</sup>*

### **Supportive Research**

<sup>6</sup> Alex H. Kral, Barrot H. Lambdin, Erica N. Browne, Lynn D. Wenger, Ricky N. Bluthenthal, Jon E. Zibbell, Peter J. Davidson, Transition from injecting opioids to smoking fentanyl in San Francisco, California, *Drug and Alcohol Dependence*, Volume 227, 2021, 109003, ISSN 0376-8716, <https://doi.org/10.1016/j.drugalcdep.2021.109003>.

<sup>7</sup> Kingston S, Newman A, Banta-Green C, Glick S. Results from the 2021 WA State Syringe Service Program Health Survey. Seattle, WA: Addictions, Drug & Alcohol Institute, Department of Psychiatry & Behavioral Sciences, University of Washington, March 2022. <https://adai.uw.edu/syringe-survey-2021>.

- **Non-Injection Routes of Drug Administration are Less Dangerous than Injection:** Injecting more frequently is associated with a greater risk of blood-borne pathogen transmission.<sup>8</sup> A person's overall drug-related risk is lowered every time they choose to smoke instead of inject. Studies have found that participants who inject drugs are often willing to switch to smoking or other modes of administration when feasible<sup>9,10</sup> and that non-injection routes of administration may pose less risk of overdose.<sup>11,12</sup> Many of the harms of injection drug use, such as endocarditis, skin infections, and vein damage, are injection-specific.<sup>13</sup> In addition to being harmful to individual health, endocarditis, HIV, and HCV are expensive to treat, and place a considerable economic burden on the public health and health care systems.<sup>14,15</sup>
- **Sharing Smoking or Snorting Supplies May Transmit Communicable and Infectious Disease:** HCV has been found on used pipes,<sup>16</sup> and sharing non-injection drug using equipment is associated with HCV infection.<sup>17</sup> Pipe sharing has also been implicated in outbreaks of other diseases, such as tuberculosis.<sup>18,19</sup> As with the risk of other respiratory infections, access to non-injection drug use materials may reduce sharing and the consequent risk of COVID-19 infection: while not yet studied with regard to illicit drugs, the sharing of tobacco cigarettes could be implicated in COVID-19 transmission through salivary droplets.<sup>20</sup>
- **People who Smoke Drugs Need Engagement and Access to Harm Reduction Services** Making pipes and other non-injection drug using supplies available can serve as an engagement strategy and bring harm reduction services to people who use drugs, but do not inject. There is a marked decrease of reported

<sup>8</sup> Thorpe LE, Ouellet LJ, Levy JR, Williams IT, Monterroso ER. Hepatitis C virus infection: prevalence, risk factors, and prevention opportunities among young injection drug users in Chicago, 1997-1999. *J Infect Dis.* 2000;182:1588-1594. doi: 10.1086/317607

<sup>9</sup> Schaeffer, D., Stoever, S., and Weichert, L. (2014), Drug consumption rooms in Europe: Models, best practice and challenges, European Harm Reduction Network <<https://www.aidsilife.de/sites/default/files/documents/Drug%20consumption%20in%20Europe.pdf>>

<sup>10</sup> Leonard L, DeRubeis E, Pelude L, Medd E, Birkett N, Seto J. "I inject less as I have easier access to pipes": injecting, and sharing of crack-smoking materials, decline as safer crack-smoking resources are distributed. *Int J Drug Policy.* 2008 Jun;19(3):255-64. doi: 10.1016/j.drugpo.2007.02.008.

<sup>11</sup> Darke, S. and Ross, J. (2000), Fatal heroin overdoses resulting from non-injecting routes of administration, NSW, Australia, 1992-1996. *Addiction*, 95: 569-573. doi:10.1046/j.1360-0443.2000.9545698.x

<sup>12</sup> Kaye S, Darke S. Non-fatal cocaine overdose among injecting and non-injecting cocaine users in Sydney, Australia. *Addiction.* 2004 Oct;99(10):1315-22. PubMed PMID: 15369570.

<sup>13</sup> Jennifer A. Frontera, Jeremy D. Gradon; Right-Side Endocarditis in Injection Drug Users: Review of Proposed Mechanisms of Pathogenesis, *Clinical Infectious Diseases*, Volume 30, Issue 2, 1 February 2000, Pages 374-379, <https://doi.org/10.1086/313664>

<sup>14</sup> Fleischauer AT, Ruhl L, Rhea S, Barnes E. Hospitalizations for Endocarditis and Associated Health Care Costs Among Persons with Diagnosed Drug Dependence — North Carolina, 2010-2015. *MMWR Morb Mortal Wkly Rep* 2017;66:569-573. DOI: <http://dx.doi.org/10.15585/mmwr.mm6622a1>.

<sup>15</sup> Tookes, H., Diaz, C., Li, H., Khalid, R., & Doblecki-Lewis, S. (2015). A Cost Analysis of Hospitalizations for Infections Related to Injection Drug Use at a County Safety-Net Hospital in Miami, Florida. *PLoS ONE*, 10(6), e0129360. <http://doi.org/10.1371/journal.pone.0129360>

<sup>16</sup> Fischer B, Powis J, Cruz MF, Rudzinski K, Rehm J. Hepatitis C virus transmission among oral crack users: viral detection on crack paraphernalia. *Eur J Gastroenterol Hepatol.* 2008;20:29-32. doi: 10.1097/MEG.0b013e3282f16a8c.

<sup>17</sup> Tortu, S., McMahon, J., Pouget, E., and Hamid, R. (2004), Sharing of Noninjection Drug-Use Implements as a Risk Factor for Hepatitis C, *Substance Use and Misuse* 39,2:211-224.

<sup>18</sup> Gardy JL, Johnston JC, Ho Sui SJ, Cook VJ, Shah L, Brodtkin E, Rempel S, Moore R, Zhao Y, Holt R, Varhol R, Birol I, Lem M, Sharma MK, Elwood K, Jones SJ, Brinkman FS, Brunham RC, Tang P.

*N Engl J Med.* 2011 Feb 24;364(8):730-9. doi: 10.1056/NEJMoa1003176. Erratum in: *N Engl J Med.* 2011 Jun 2;364(22):2174.

<sup>19</sup> Andrea A. Howard, Robert S. Klein, Ellie E. Schoenbaum, Marc N. Gourevitch; Crack Cocaine Use and Other Risk Factors for Tuberculin Positivity in Drug Users, *Clinical Infectious Diseases*, Volume 35, Issue 10, 15 November 2002, Pages 1183-1190, <https://doi.org/10.1086/343827>

<sup>20</sup> Ahmed N, Maqsood A, Abduljabbar T, Vohra F. (2020). Tobacco Smoking a Potential Risk Factor in Transmission of COVID-19 Infection. *Pak J Med Sci*, 36(COVID19-S4):S104-S107

drug-related health problems among people who obtain new pipes through SSPs<sup>21</sup> and SSPs serve as a point of entry to other services, including access to overdose education and naloxone, infectious disease testing (e.g., HIV, HCV, and syphilis), linkage to care, primary care, and recovery support and treatment services.<sup>22</sup>

- ***Opioid and Psychostimulant Overdose are a Public Health Crisis Requiring Innovative Approaches*** Per provisional DOH overdose surveillance data, drug-related overdose deaths surpassed 2,000 in 2021, a more than 66 percent increase compared to 2019. In 2019, the number of overdose deaths involving a synthetic opioid (mostly fentanyl and fentanyl analogs) was 337; in 2020 there were 672 (an increase of 99%), and preliminary 2021 data has this number as 1181 (a 250% increase from 2019). In addition, psychostimulant and polydrug overdose are on the rise: in 2019, the number of overdose deaths involving a psychostimulant was 540; in 2020, there were 728 (an increase of 35%), and preliminary 2021 data counts 1,112 (a 105% increase from 2019). In 2021, overdose deaths in Washington disproportionately affected people 45 years of age and younger, and Black, Indigenous/Native American/Alaska Native, and Hispanic/Latino/Latina/Latinx communities. Increases in overdose deaths demonstrate the need to expand services to engage all people who use drugs, and particularly people from disparately impacted communities, in overdose prevention and naloxone distribution, as well as linkages to health and social services.
- ***Syringe exchange program participants are more likely to reduce or end use of injection drugs and to remain in treatment:*** A study published in the *Journal of Substance Abuse Treatment* in 2000<sup>23</sup> found that injection drug users who had formerly been exchange users were more likely than never-exchangers to report a substantial reduction in injection, to stop injecting altogether, and to remain in drug treatment. New users of the exchange were five times more likely to enter drug treatment than never-exchangers. The researchers concluded that reduced drug use and increased drug treatment enrollment associated with needle exchange participation may have many public health benefits, including prevention of blood-borne viral transmission.
- ***Needle exchange programs are a bridge to treatment:*** Another study, published in the *Journal of Urban Health: Bulletin of the New York Academy of Medicine*, assessed the role of needle-exchange programs (NEPs) as a bridge to treatment<sup>24</sup>. Researchers found that needle-exchange attendance was associated independently with entering detoxification for both HIV-infected and uninfected injection drug users.

21 Prangnell, A., Dong, H., Daly, P., Milloy, M. J., Kerr, T., & Hayashi, K. (2017). Declining rates of health problems associated with crack smoking during the expansion of crack pipe distribution in Vancouver, Canada. *BMC Public Health*, 17, 163. <http://doi.org/10.1186/s12889-017-4099-9>

22 Fischer B, Rehm J, Patra J, Kalousek K, Haydon E, Tyndall M, El-Guebaly N. (2006) *Addiction*. Dec;101(12):1760-70.

23 Holly Hagan, MPH, PhD., et al., "Reduced injection frequency and increased entry and retention in drug treatment associated with needle-exchange participation in Seattle drug injectors," *Journal of Substance Abuse Treatment*, Volume 19, Issue 3 (2000), pgs 247-252

24 Stephanie A. Strathdee, et al., "Needle-exchange attendance and health care utilization promote entry into detoxification," *Journal of Urban Health: Bulletin of the New York Academy of Medicine*, Vol 76, Number 4 (1999).

**Financial Impact:**

Dollars	FY23	FY24	FY25
5476 Funding	N/A	N/A	N/A
Grant Funding	N/A	N/A	N/A
Total Funds	N/A	N/A	N/A
Staff (FTE)	0	0	0

**Consideration of youth, rural areas, and tribes:**

Youth: Youth are dying from drug use at higher rates than they ever have (although rates of drug use itself has not necessarily increased) This recommendation should consider and allow programs to legally provide supplies to people 18 and younger.

Rural Areas: It is becoming increasingly difficult in rural areas to engage those most at risk of overdose with limited supplies allowed. Traditional harm reduction services are not accommodating the needs of people at risk of overdose, and the ability to distribute harm reduction supplies would strengthen programs’ ability to engage and support these rural communities. When transportation to services is difficult – such as in rural areas –receiving drug checking supplies, etc., serve as the necessary incentive for engagement. Due to limited resources and treatment options in rural areas, harm reduction may be the only option for some people who use drugs to receive support services that improve their health, safety, and wellbeing.

Tribes: American Indian/Alaska Native people in Washington State have disproportionately high rates of fatal overdoses and experience higher rates of stigma when accessing conventional services. Expanding access to and engagement with harm reduction services is critical and necessary to improve the health and save the lives of AIAN people in Washington.

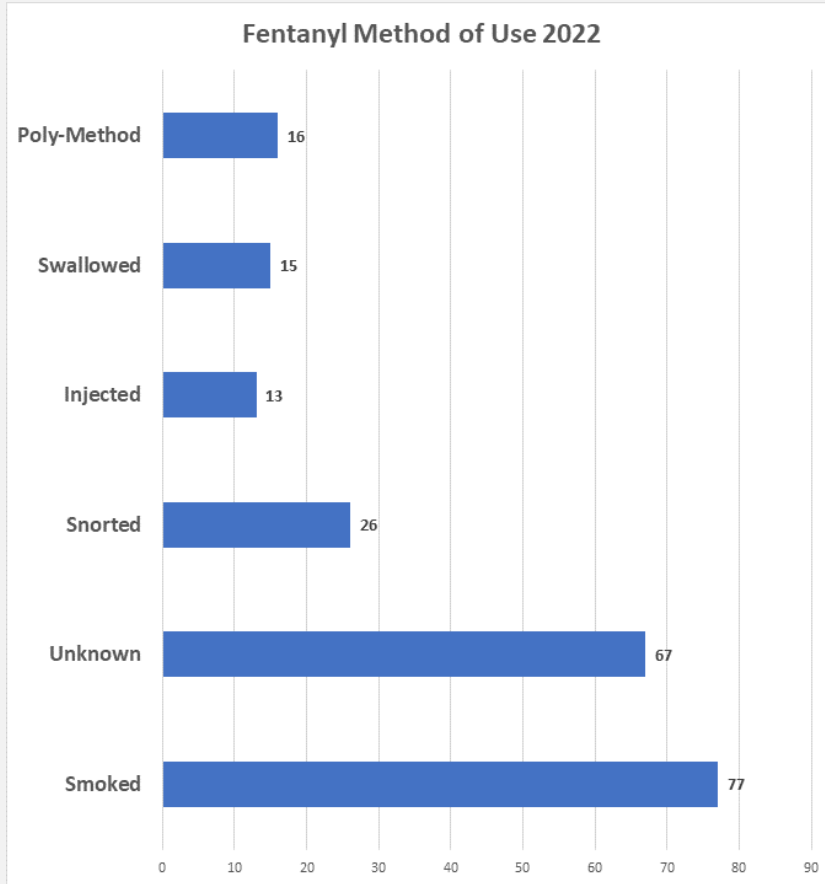
**Collaboration/Existing Programs:**

*[RCW 69.50.4121: Drug paraphernalia—Selling or giving—Penalty. \(wa.gov\) \(3\) Nothing in subsection \(1\) of this section prohibits legal distribution of injection syringe equipment through public health and community based HIV prevention programs, and pharmacies.](#) RCW 69.50.4121 (3) is a technical amendment which allows certain entities to distribute syringe injection equipment – an additional technical amendment would impact all programs/individuals engaging to support the health of people who use drugs.*

WA HCA contracted with ADAI to implement community drug checking services at harm reduction sites across WA. The project includes the use of fentanyl and benzodiazepine test strips and Fourier Transformation Infrared Spectroscopy chemical analysis. It is expected that these services will encourage the participation of new clients, including those who smoke drugs who did not previously attend syringe services programs. In turn some harm reduction programs may wish to expand their supplies to include safer smoking equipment.

**SURSA Committee feedback**

2022 King County medical examiner data suggest a substantial proportion of people dying from drug overdoses involving fentanyl smoked their drugs, a major shift from heroin in previous years which was predominantly injected. Data from William Barbour in the KCME office via Caleb Banta-Green. These are 214 deaths from 1/1/22-7/13/22 from data provided on 7/14/22.



The Tacoma Needle Exchange (TNE) reported seeing hundreds of new clients when they began offering safer smoking equipment/pipes. From the ADAI report with data provided by Paul LaKosky from TNE:

The Tacoma Needle Exchange launched a pilot project to distribute smoking supplies at one of their sites in December 2020. In one year, 1,146 unique individuals received services at that site, of whom 742 (64%) were new participants, many coming to the site for the first time specifically to access smoking equipment. Over the year, participants received safer smoking supplies in 94% (3,237) of the 3,979 total encounters at the site, which demonstrates the high demand for safer smoking supplies.<sup>25</sup>

<sup>25</sup> [Singh S, Banta-Green C, Kingston S. Distribution of Safer Drug Smoking Supplies as a Public Health Strategy. Seattle, WA: Addictions, Drug & Alcohol Institute, University of Washington, January 2022. https://adai.uw.edu/wordpress/wp-content/uploads/SaferSmokingBrief\\_2022.pdf](https://adai.uw.edu/wordpress/wp-content/uploads/SaferSmokingBrief_2022.pdf)

## Appendix G – Recommendation 6: BH-ASO and RNP data reporting

**Recommendation** – (1) Establish specific data collection and reporting requirements among Behavioral Health Administrative Services Organizations (BH-ASOs) related to their regional [recovery navigator programs](#) (RNPs); (2) Identify data to be included in the RNP quarterly reports for SURSAC review to monitor program effectiveness and inform recommendations for improvements.

**Bill Requirement(s)** – This recommendation pertains to ESB 5476 Section 1.3(h), related to “reporting requirements by behavioral health administrative service organizations [BH-ASOs] to monitor the effectiveness of the [Recovery Navigator] programs and recommendations for program improvement,” as well as Section 2.5: “Each recovery navigator program must submit quarterly reports to the authority with information identified by the authority and the substance use recovery services advisory committee [SURSAC] for discussion at meetings following the submission of the reports.”

### **Background**

As a key aspect of the Plan and the state’s response to the State v. Blake supreme court ruling, the Recovery Navigator Program was initiated as soon as possible following the passing of 5476. [Uniform Program Standards](#) were established, and HCA developed a draft data collection workbook for use by the BH-ASOs and RNP contractors to enable data collection as soon as the programs became operational and open to referrals. The data collection workbook was further informed by meetings with the LEAD Bureau and input from the BH-ASOs.

At the monthly meetings on March 7<sup>th</sup> and April 4<sup>th</sup>, the SURSAC was asked to provide feedback for the RNPs regarding what data to include in the quarterly reports that would help the SURSAC assess the effectiveness of the programs and make recommendations for program improvement. Those notes were collected and forwarded to the RNP leads at HCA on April 25<sup>th</sup> in a document titled, “Section 1.3(h) – RNP Data Collection and Reporting.”

Although the feedback from SURSAC has already been provided to the RNPs for immediate implementation where feasible, this formal recommendation aims to summarize and confirm the following:

Part I: Current BH-ASO data collection activity, which was informed by meetings with the LEAD Bureau, input from the BH-ASOs, and SURSAC

Part II: New BH-ASO data collection recommendations that could be implemented immediately given current staffing, funding, and other capacities

Part III: Recommendations for RNP Quarterly Report content to be provided to SURSAC as part of RNP monitoring

Part IV: Data collection and reporting recommendations that are contingent on the implementation of a data integration system that would make them possible

*Part I: Current State of BH-ASO Data Collection*

The BH-ASOs are not collecting data directly. The BH-ASOs have contracted with local providers, and those providers have hired staff who are collecting the data that is being tracked in the data collection workbook described below. The staff collecting these data do not have full knowledge of, or access to, the comprehensive system of services that people are utilizing.

The following data elements are being collected via the Data Collection Tool Excel workbooks in a uniform manner across all regions so they can be combined and reviewed for statewide, as well as regional, analysis (see Appendix A for details).

The workbooks that contain these data are shared with HCA, from which HCA can summarize (and conduct analyses when possible) and share, in aggregate, within the RNP Quarterly Reports that are provided to SURSAC for review.

Referral and Outreach Data

- ❖ **Unique identifiers** that can be linked to outcomes (i.e., services received, arrests, health) to demonstrate overall impact of each RNP and prevent unintentional client duplication. Currently, BH-ASOs are collecting clients’ first and last names, dates of birth, social security numbers, and Provider One IDs as forms of unique identifying information, as well as creating a unique client ID for each individual who enrolls in RNP case management.
- ❖ **Referral source** (e.g., child welfare, law enforcement, self-referral, etc.)
- ❖ **Referral reason** (e.g., safety concern, in crisis, frequent contact with law enforcement, etc.)
- ❖ **Referral location** (address/location from which referral call is made)
- ❖ **Demographic Information:** BH-ASOs are collecting individual-level demographic data at referral intake, which can be used to provide a demographic distribution summary for all other data points collected by the RNP. Each Policy Coordination Group (PCG) is required to gather individual demographic data for all RNP participants, including (but not limited to) age, gender identify, sexual orientation, race, and ethnicity. In the aggregate, such data are necessary and relevant to enable robust analysis, including analyses related to racial equity. BH-ASOs are collecting the following demographic data for each person referred to the RNP:
  - **Race**
  - **Ethnicity**
  - **Gender**
  - **Sexual Orientation**
  - **Source of Income / Support** (to identify who may qualify for state benefits such as ABD or social security disability)



- **Housing Status**

- ❖ **Outreach Outcome** (e.g., not interested in services, consent signed, individual could not be reached, etc.)
- ❖ **Screening Outcome and Case Management Level** (e.g., declined services, enrolled in intensive care, etc.)
- ❖ **Direct Client Services Provided by RNP** (e.g., Naloxone, bus pass, clothing, hygiene products, shelter, etc.)

Case Management Data

- ❖ **Case management phase / engagement level** (light or intensive case management)
- ❖ **Contingency Management Participation** (yes/no)
- ❖ **Outreach follow-up** (yes/no)
- ❖ **Referral to services made** (multiple selection, see Appendix A for options)
- ❖ **Linkage to Care / Warm Hand Off** (multiple selection, see Appendix A for options)
- ❖ **Release of Information (ROI) signed** (yes/no)
- ❖ **Consent form signed** (yes/no)
- ❖ **Individualized Service Plan Created/Updated** (yes/no)

Engagement Report

The following information is also provided quarterly to HCA within each BH-ASO's Data Collection Tool (PCG = Policy Coordinating Group; OWG = Operational Workgroup):

- ❖ **Frequency of PCG and OWG meetings** (measure of stakeholder engagement)
- ❖ **Partner attendance at PCG and OWG meetings** (measure of stakeholder engagement)
  - Number of attendees
  - Representation from law enforcement, prosecution, public defense, government agencies, community advocacy groups, service providers, other relevant local stakeholders

## SUBSTANCE USE AND RECOVERY SERVICES PLAN

How often did your PCG and your OWG meet this quarter?			
Meeting Day/Time	Frequency	Counties Covered	Identify meeting participants job titles
<b>List PCG Meetings in Region</b>			
<b>PCG</b>			
<b>OWG</b>			
Please discuss any barriers to the development and ongoing operations of the PCG and OWG.			
How many times has the team engaged in technical assistance this quarter? Are you receiving the level of technical assistance that you need?			
Recovery Navigator Program(s) worked with community groups/business groups this quarter to coordinate approaches and encourage referrals.			
<b>New Engagements</b>	<b>Total Engagements</b>	<b>New Enrollments</b>	<b>Total Enrollments</b>
Recovery Navigator Program(s) worked with existing outreach programs, families, fire/EMS, hospitals, homeless shelters, and faith-based organizations to coordinate care and encourage referrals.			
<b>New Engagements</b>	<b>Total Engagements</b>	<b>New Enrollments</b>	<b>Total Enrollments</b>

### *Part II: New Recommendations for BH-ASO Data Collection (Immediate Implementation)*

#### BH-ASO Data Collection

- ❖ Seek funds to implement a data integration platform that can serve both as a common database for diversion efforts across the state and as a data collection and management tool for practitioners. If possible, leverage existing platforms already in use by HCA-funded efforts and any closed loop referral systems implemented in the future.
- ❖ Establish a quality assurance process for BH-ASOs to ensure that data in the data collection workbooks are clean, complete, and accurate before submitting to HCA, and a plan in place for data that is deemed out of bounds / unverified for submission
- ❖ Where applicable, add data validation to data fields in the data collection workbook (e.g., only dates accepted under DOB and date of referral, only 7-digit numbers accepted in Provider One ID, etc.)

### *Part III: Recommendations for RNP Quarterly Report Content*

It is expected that RNP clients will be engaged in long-term, intensive case management. While some “light touch” participants could see significant individual benefits in a relatively short period of time, many individuals will have complex co-occurring challenges, including extensive criminal-legal system contact. For these participants, progress toward health, wellness, and stability is expected to take much longer than a year, so evaluations of the RNP in its early years should include formative measures and measures of change (in knowledge, attitudes, or actions) for systems stakeholders, not only data that can assess participant-level formative and outcome metrics. These metrics should include:

- ❖ **Referral Response Time** (average and range)
- ❖ **Narrative description of referral processes** available for the RNP and any changes to referral processes that have occurred in the quarter
- ❖ **Frequency of community referral source and referral source percentages, statewide and for each BH-ASO:** Number of referrals from different community sources (e.g., casinos, child welfare, family member, etc.)
  - Implement system to add and track referral sources based on submissions in “other” category into the tracking sheets
- ❖ **Demographic summaries of RNP outreach and referral data, statewide and by BH-ASO:** Total number, racial/ethnic composition, gender composition, sexual orientation composition, and housing status of populations:
  - Referred to RNP through law enforcement diversion
  - Referred through law enforcement social contact
  - Referred through community referral processes
  - Referred but not enrolled (outreach referral)
  - Agreeing to outreach but not case management (outreach status)
  - Enrolled in light case management
  - Enrolled in intensive case management
- ❖ **Frequency of reasons for referral statewide and for each BH-ASO:** Number of referrals made for different reasons (e.g., concern for public safety, concern for self-harm, unlawful possession of controlled substances, etc.)
- ❖ **Number and Types of Direct Client Services Received, statewide and by BH-ASO:** Number and types of services received directly from RNP (e.g., Naloxone, housing voucher, bus pass, etc.)
- ❖ **Number and types of services participants have been referred to, statewide and by BH-ASO** (e.g., healthcare, transportation, behavioral health services, legal services, employment assistance, public benefits, withdrawal management, SUD assessment, outpatient treatment, inpatient treatment, community support organization, housing support, etc.)
- ❖ **Number and types of services to which participants have received warm hand-off and engaged in services, statewide and by BH-ASO** (e.g., healthcare, transportation, behavioral health services, legal services, employment assistance, public benefits, withdrawal management, SUD assessment, outpatient treatment, inpatient treatment, community support organization, housing support, etc.)

- ❖ **Number and attendance of PCG meetings, statewide, by BH-ASO, and by local RNP:** Number of PCG meetings, attendance by representatives with decision-making power from law enforcement, prosecution, public defense, service providers, local behavioral health and other government agencies, advocacy organizations, and other local community partners as relevant.
- ❖ **State Census Data** (source: Office of Financial Management)

*Part IV: Future Evaluation Recommendations Contingent on New Data Infrastructure*

While the impacts of a systems-change initiative like RNP are unlikely to be seen within the first few years, Washington State should currently work to establish the necessary capacities and processes to enable both formative evaluation and summative evaluation of effectiveness. This will likely require the integration of a new data infrastructure or processes that can exploit existing and new streams of data pertaining to an individual’s criminal legal system encounters/involvement, and the outreach, treatment, and recovery support services they receive through RNPs.

Collection of the metrics below should commence – and be included in RNP quarterly reports -- once a data infrastructure has been established that supports user-friendly data collection and management for practitioners:

System utilization

- Use of emergency medical services
- Emergency Department utilization
- Arrest, days in jail
- **New charges with incident date after of referral to RNP** (broken into felony, misdemeanor), to be added to Case Management tab in RNP Data Collection tool
- **Convictions with incident date after date of referral to RNP** (broken into felony / misdemeanor), to be added to Case Management tab in RNP Data Collection tool
- Access to and engagement with culturally appropriate, non-punitive, community-based resources

System response

- Capacity and variety of local services aligned with RNP’s commitment to harm reduction and holistic care
- Number and percent of substance-possession related law enforcement encounters that result in arrest, booking, and/or convictions for RNP-eligible behaviors, as well as the demographics of those individuals engaged by law enforcement in these encounters
- **Racial disparity analysis** that compares demographics of individuals who are arrested and booked into jail, compared to the demographics of those who are referred to RNP, among diversion-eligible individuals

Quality of life

- Self-report quality life/well-being
  - Improved mental and physical health
- ❖ **Services and Access Gap Analysis:** Indicated by comparing services needed/requested by RNP participants, referrals made, referred services received by BH-ASO region, and reasons why services were not received (if applicable). If the data collection burden for case managers is too great for this level of analysis, request that case managers report areas where service gaps are a persistent problem.
  - ❖ **Participant Satisfaction:** Collected via survey every six months following enrollment in RNP, with procedures in place outlining minimum and maximum contact efforts and whether anyone (e.g., those who un-enroll from RNP case management, or move out of state) should not be included in follow-up data
  - ❖ **Number and percent of substance-possession related law enforcement encounters that result in RNP referral:** The BH-ASOs will be tracking “source of referral” for each RNP participant, which includes referrals from law enforcement officers, so the quarterly reports can include # and % of referrals from LEO to the RNP. However, this new recommendation refers to numbers indicating the percent of LEO encounters or arrests that do and do not lead to RNP referral – and the associated demographics. Since the BH-ASOs do not have access to this law enforcement encounter data, implementation of this recommendation is contingent on having a method for collecting such data.
  - ❖ **Demographics of non-diverted arrests** for RNP-eligible behaviors

### Approximate Financial Support and Staffing Needed:

Funding to execute Parts I-III are secured with the existing RNP budgets (approximately \$20 million per year).

Implementation of Part IV would require additional funding to support the following:

- Investment in the software selected by the state to create the necessary infrastructure
- Technical Assistance to setup and provide ongoing technical support to every BH-ASO to implement the new data
- At least one FTE to manage data coordination with the new infrastructure and prepare data for RNP quarterly reports that are out of scope for the BH-ASOs to collect

### Collaboration with Existing Resources:

- ❖ *Law Enforcement jurisdictions*
- ❖ *Behavioral Health Administrative Services Organizations*
- ❖ *Community behavioral health treatment and recovery support services providers*

### SURSA Committee feedback

The overall data structure/architecture isn't clear – it would be helpful if this were diagrammed.

Unfortunately, we don't have time to create a diagram in time to provide prior to the SURSAC vote, but this could be provided at a later point for clarification. The data infrastructure that could provide these types of diagrams are captured in the 2<sup>nd</sup> data recommendation, #13.

**“Services received” isn't an outcome. “Effectiveness,” which is the standard in the law, is a measure of actual outcomes, e.g., health, arrest, not process or services received.**

When the subcommittee discussed this, the general consensus was that “services received” can be considered an outcome if providing services to RNP enrollees is one of the goals of the program. However, the point was well taken that “receiving services” does not measure improvement of quality of life in and of itself, and “arrests” and “health” have been added as examples of outcomes that could more directly capture overall effectiveness.

**Collecting Provider One IDs as a unique identifier only helps for people who get public funding. What about SSN, and trying to link to the all payer claims database?**

Omitting “social security numbers” from the initial list of unique identifiers was an oversight, and that has been added. First name, last name, date of birth, and social security number should be sufficient unique identifiers. During implementation, the feasibility of using these unique identifiers to link to data from the All Payers Claims Database can be explored.

**(Referring to page 2, “Direct Client Services Provided by RNP”): Naloxone, bus passes, clothing, hygiene products, etc. are supplies, not services.**

The subcommittee views “providing supplies” as a service, and this is the language used in the RNP Workbooks. If this issue should be pursued further, “Direct Client Supports” could be an alternate way to phrase this in the workbooks and reports.

**Somewhere there should be a safety/harm reduction plan and services identified separately from direct services provided.**

These types of services are outlined in the client's individualized service plan

**How is contingency management measured – that they indicate they want to start, that they do start, how many sessions, results? Y/N is inadequate to document receipt of contingency management.**

Contingency Management participation is tracked in the workbook (see Appendix A) with a new entry for each engagement, so each engagement prompts a Y/N outcome, as opposed to a single Y/N response to indicate whether they are participating in CM in general or not.

**Unless “referral response time” is tracked in real time, it doesn't seem such summary data would be available.**

While a warm hand-off is ideal – in which case there would be effectively no time between referral and response – there will be situations when there will still be a time gap between the initial referral and when the RNP can respond to that referral. This data (date/time of referral, date/time of response, and time elapsed between the two) is being collected in the workbooks (see Appendix A), so it will be available. The subcommittee would like clarification for what is meant by “real time,” if this response does not address the concern.

Not sure what you mean by “formative and summative evaluation.” The law specifies “effectiveness” which mean real world outcomes utilizing individual level data. Presumably with some quasi-experimental design, either within-person longitudinal or a comparison group.

We may be able to use quasi experimental design to assess effectiveness, as well as other measures of effectiveness.

**“Use of Emergency Medical Services” data is very hard to get, vs. health care utilization, e.g., Emergency Department of hospitalization/CHARS. Do you think you’ll get this from WEMISIS?**

The source of this data would need to be determined if/when new data infrastructure (outlined in the other data recommendation, #13) is implemented. In the meantime, “Emergency Department utilization” has been added below “Use of Emergency Medical Services,” as that is a measure of interest as well.

Appendix C-1: BH-ASO Data Collection Tool for RNPs

<sup>BHDS</sup>= Dropdown options (demographic fields) aligned with Behavioral Health Data System

Referral and Outreach Data

Data Element	Data Type / Validation
Provide One ID	7-digit numeric-only entry (data validated)
Client ID	8-character alpha-numeric: Aa11aa11
First Name	Letters only
Last Name	Letters only
Alternate Name / AKA	Letters only
Date of Birth	Indicate “unknown” if not collected
Date of Referral	mm/dd/yy
Time of Referral	Please use 24 Hour clock (3:15pm = 15:15)
Referral Response Time	Please use 24 Hour clock (3:15pm = 15:15) URBAN response time goal: within 30-45 minutes RURAL response time goal: within 60-90 minutes
Referral Source	SINGLE SELECTION: <ul style="list-style-type: none"> <li>• Business Community</li> <li>• Casinos</li> <li>• Child Welfare</li> <li>• Community Based Organization</li> <li>• Criminal Legal System (e.g., Probation, Pretrial Services)</li> <li>• Emergency Department</li> <li>• Faith-Based Organization</li> <li>• Family Member</li> <li>• Fire/EMS</li> <li>• Harm Reduction Program (SSP)</li> <li>• HealthCare Referral</li> <li>• Homeless Encampment</li> <li>• Law Enforcement – Arrest Diversion</li> <li>• Law Enforcement – Social Contact Referral</li> <li>• Motels</li> <li>• Outreach</li> <li>• Self-Referral</li> </ul>



SUBSTANCE USE AND RECOVERY SERVICES PLAN

	<ul style="list-style-type: none"> <li>• Social Contact</li> <li>• Other</li> </ul>
Referral Reason	<p>SINGLE SELECTION:</p> <ul style="list-style-type: none"> <li>• Concern about safety of others</li> <li>• Concerns about self-harm</li> <li>• Unlawful possession of controlled substance (ESB 5476)</li> <li>• Frequent contact with law enforcement (LE)</li> <li>• In crisis</li> <li>• Interfering with business</li> <li>• Solicitation</li> <li>• Theft</li> <li>• Other</li> </ul>
Location of Referral / Outreach	<p>Full street address if known          Alternatively: list location and zip code (e.g., Seeley Lake Park, 98499)</p>
Race <sup>BHDS</sup>	<p>MULTIPLE SELECTION:</p> <ul style="list-style-type: none"> <li>• American Indian / Alaska Native</li> <li>• Asian Indian</li> <li>• Black or African American</li> <li>• Cambodian</li> <li>• Chinese</li> <li>• Filipino</li> <li>• Guamanian or Chamorro</li> <li>• Native Hawaiian</li> <li>• Japanese</li> <li>• White</li> <li>• Korean</li> <li>• Laotian</li> <li>• Middle Eastern</li> <li>• Other Asian</li> <li>• Other Pacific Islander</li> <li>• Other Race</li> <li>• Unknown</li> </ul>
Ethnicity <sup>BHDS</sup>	<p>MULTIPLE SELECTION:</p> <ul style="list-style-type: none"> <li>• Cuban</li> <li>• Hispanic – Specific Origin Unknown</li> <li>• Mexican</li> <li>• Not of Hispanic Origin</li> <li>• Other Specific Hispanic (e.g. Chilean)</li> <li>• Puerto Rican</li> <li>• Unknown</li> <li>• Refused</li> <li>• Not Collected</li> </ul>
Gender <sup>BHDS</sup>	<p>SINGLE SELECTION:</p>

SUBSTANCE USE AND RECOVERY SERVICES PLAN

	<ul style="list-style-type: none"> <li>• Female</li> <li>• Male</li> <li>• Transgender</li> <li>• Intersex</li> <li>• Transgender Female</li> <li>• Transgender Male</li> <li>• Unknown</li> </ul>
Sexual Orientation <sup>BHDS</sup>	<p>SINGLE SELECTION:</p> <ul style="list-style-type: none"> <li>• Heterosexual</li> <li>• Gay/Lesbian/Queer/Homosexual</li> <li>• Bisexual</li> <li>• Questioning</li> <li>• Choosing not to disclose</li> </ul>
Source of Income / Support <i>per Sec 1.3(m)</i>	<p>SINGLE SELECTION</p> <ul style="list-style-type: none"> <li>• Wage/Salary</li> <li>• Public Assistance</li> <li>• Retirement pension</li> <li>• Disability</li> <li>• Other</li> <li>• None</li> <li>• Unknown</li> <li>• Not collected</li> </ul>
Housing Status <sup>BHDS</sup>	<p>SINGLE SELECTION:</p> <ul style="list-style-type: none"> <li>• Homeless without housing</li> <li>• Foster home/ foster care</li> <li>• Residential care</li> <li>• Crisis residence</li> <li>• Institutional setting</li> <li>• Jail / correctional facility</li> <li>• Private residence</li> <li>• Independent living</li> <li>• Dependent living</li> <li>• Private residence – youth</li> <li>• Other residential status</li> <li>• Homeless with Housing</li> <li>• Unknown</li> </ul>
Screening Outcome / Case Management Level	<p>SINGLE SELECTION:</p> <ul style="list-style-type: none"> <li>• Outreach referral (declined services)</li> <li>• Outreach status</li> <li>• Enrolled in light case management</li> <li>• Enrolled in intensive case</li> </ul>
Direct Client Services	<p>MULTIPLE SELECTION:</p> <ul style="list-style-type: none"> <li>• Naloxone</li> <li>• Shelter (e.g. housing, motel voucher, sleeping bag)</li> <li>• Coffee</li> </ul>

**SUBSTANCE USE AND RECOVERY SERVICES PLAN**

	<ul style="list-style-type: none"> <li>• Food/Gift Card</li> <li>• Hygiene Products</li> <li>• Family Support Services (e.g. childcare, diapers, food)</li> <li>• Bus pass</li> <li>• Medical expenses</li> <li>• Clothing</li> <li>• Other</li> <li>• Multiple Resources Provided</li> </ul>
Outreach Outcome	<p>MULTIPLE SELECTION:</p> <ul style="list-style-type: none"> <li>• Not interested in services</li> <li>• Consent signed</li> <li>• Exchanged contact information</li> <li>• ROI signed – enrolled</li> <li>• Unsuccessful contact attempt (i.e., person absconded)</li> <li>• Provided list of resources</li> <li>• Called Crisis Services</li> <li>• Scheduled Follow-up meeting</li> <li>• Individual arrested after referral</li> <li>• Other</li> </ul>

Case Management Data

New entry (row of data) created for each case management event

Provider One ID	7-digit numeric-only entry (data validated)
Client ID	8-character alpha-numeric: Aa11aa11
Date of Case Management Event	Mm/dd/yy
Case Management Phase / Engagement Level	<p>SINGLE SELECTION:</p> <ul style="list-style-type: none"> <li>• Light case management</li> <li>• Engaged/intensive case management</li> </ul>
Contingency Management (Participation)	<p>SINGLE SELECTION:</p> <ul style="list-style-type: none"> <li>• Yes</li> <li>• No</li> </ul>
Outreach Follow-Up	<p>SINGLE SELECTION:</p> <ul style="list-style-type: none"> <li>• Yes</li> <li>• No</li> </ul>
Referral to Services Made	<p>MULTIPLE SELECTION:</p> <ul style="list-style-type: none"> <li>• Basic Needs e.g. hygiene, food, clothing</li> <li>• Public Benefits (e.g. DES, Social Security, Health Insurance)</li> <li>• Physical healthcare referral</li> <li>• SUD Referral – Withdrawal Management</li> <li>• SUD Referral – Assessment</li> <li>• SUD Referral – Outpatient</li> <li>• SUD Referral – Inpatient</li> </ul>

SUBSTANCE USE AND RECOVERY SERVICES PLAN

	<ul style="list-style-type: none"> <li>• Community Support Organization (Recovery Café, other nonprofit)</li> <li>• Self Help Support Group (AA/NA/Alanon/SMART recovery/etc)</li> <li>• Faith-based organization</li> <li>• Housing</li> </ul>
Linkage to Care (Warm Hand-Off)	<p>MULTIPLE SELECTION:</p> <ul style="list-style-type: none"> <li>• Basic Needs e.g. hygiene, food, clothing</li> <li>• Public Benefits (e.g. DES, Social Security, Health Insurance)</li> <li>• Physical healthcare referral</li> <li>• SUD Referral – Withdrawal Management</li> <li>• SUD Referral – Assessment</li> <li>• SUD Referral – Outpatient</li> <li>• SUD Referral – Inpatient</li> <li>• Community Support Organization (Recovery Café, other nonprofit)</li> <li>• Self Help Support Group (AA/NA/Alanon/SMART recovery/etc)</li> <li>• Faith-based organization</li> <li>• Housing</li> </ul>
ROI Signed	<p>SINGLE SELECTION:</p> <ul style="list-style-type: none"> <li>• Yes</li> <li>• No</li> </ul>
Consent Form Signed	<p>SINGLE SELECTION:</p> <ul style="list-style-type: none"> <li>• Yes</li> <li>• No</li> </ul>
Individualized Service Plan Created / Updated	<p>SINGLE SELECTION:</p> <ul style="list-style-type: none"> <li>• Yes</li> <li>• No</li> </ul>

## Appendix H – Recommendation 7: Health Hubs

**Recommendation** – *Establishing Health Engagement Hubs to serve as an all-in-one location where people who use drugs can access a range of medical, harm reduction, and social services*

**Bill Requirement(s)** – Developing Health Engagement Hubs for people who use drugs considers and supports several elements that 5476 outlined for inclusion in the Substance Use Recovery Services Plan:

- Points of intersection that persons with substance use disorder have with the health care system (ESB 5476 §1.3.a)
- Locations in which persons with untreated substance use disorder congregate (ESB 5476 §1.3.a)
- New community-based care access points (ESB 5476 §1.3.b)
- Barriers to accessing the existing behavioral health system (ESB 5476 §1.3.d)
- Innovations that could improve the quality and accessibility of care for persons with co-occurring substance use disorders and mental health disorders, and populations chronically exposed to criminal legal system responses (ESB 5476 §1.3.d)

### **Consideration of youth, rural areas, and tribes:**

**Youth:** These Health Engagement Hubs would be open to youth as well as adults. [Ryther/YouthCare](#) in Seattle provides young adult models that combine outreach with fixed site, which can be used to help inform ways to make these hubs appropriate and effective for youth.

**Rural Areas:** Health Hub mobile treatment services will provide support to rural areas that do not have a brick-and-mortar hub.

**Tribes:** Sufficient funding will be provided to each tribe to establish, or invest in already existing, hubs for people who use drugs, so that they can decide which services to provide via the Health Hubs that are best suited to each tribe’s needs.

### **Recommendation Details**

We propose **Health Engagement Hubs** to be affiliated with an existing SSP serving each community as well as other entities as appropriate, including Federally Qualified Health Centers (FQHCs)/Community Health Centers (CHCs), patient centered medical homes, overdose prevention/safe consumption sites, peer run organizations (e.g., Club Houses), services for unhoused people, supportive housing, and opioid treatment programs. Harm reduction services and supplies must be an integral program component of any organization housing a health hub.

The hubs would prioritize communities disproportionately impacted by the harms associated with opioid and other drug related harm, including American Indian/Alaska Native communities, Black/African American communities, Latino/Hispanic communities, people experiencing homelessness, and communities impacted by the criminal-legal system. Programs may operate in fixed sites or could be mobile clinics.

Services should address each of the care domains below, with as comprehensive a service mix as feasible:

- Comprehensive physical and behavioral health care including: primary care, wound care, infectious disease vaccination, testing, and treatment, and sexual and reproductive health care services (including pre- and post-natal supports like doulas), dental care, ophthalmology, low-barrier buprenorphine (and other medications for SUD as available), contingency management services, appropriate client-centered-assessment and linkage for diverse substance use disorder treatment services e.g., harm reduction counseling and treatment services, “traditional”, and mental health care services.
- Medical case management services/care coordination (could include doula support).
- Harm reduction services and supplies- Overdose education, naloxone distribution, and drug checking services. Safer drug use supplies and safer sex supplies. Other basic needs including food, clothing, and basic hygiene supplies.
- Community health outreach workers/navigators, peer health educators, and peer recovery coaches with the ability to engage community members about the hub, engage people who use drugs in services, transport people to the hub, and to transport people to other service locations, as needed. These staff will participate in community provider meetings including ED, jail, public health, behavioral health, detox, housing, and others to create referral pathways and professional relationships that support clients accessing a complete continuum of care with no wrong door.
  - The job is about non-judgmental support, not about “putting people in their place”. Power dynamics need to be carefully considered.
  - Quality staff supervision and support is essential to promote high quality care and staff wellbeing.
- Linkage to housing, transportation, and other support services.
- Spiritual Connection Communities: Among those for whom substance addictions are experienced as spiritual crises, spaces for spiritual and social connection are essential to restoring a hopeful and self-directed life. Therefore, it is important that these hubs create space for, or provide linkage to, spiritually-oriented communities that are as diverse as the communities and the people they would like to engage. Spirituality is one of the biggest drivers, motivators, and natural “community” for people to connect and be well with, especially for tribes. People who use are in a form of community, and that sense of community needs to be maintained as they transition into healthier environments. Pulling them out into isolation, marginalization does not promote healing.

Health Engagement Hubs should encourage community volunteers, and provide appropriate training to staff and volunteers, including diversity, equity, and inclusion training.

Services should be offered in coordination with every willing SSP. Communities with an SSP may also offer services in other settings described above. Communities without an SSP may provide services in another setting given they institute a substantial harm reduction service and staffing continuum.

A health hub should be available within a one-hour drive of every location in Washington State, with the exception of frontier designated areas where they should be available within a two-hour drive.

### Background and Supporting Data

This recommendation draws most immediately from a [State Opioid and Overdose Response Plan \(SOORP\)](#) proposal authored by the Washington State Department of Health (DOH) including Emalie Hurliaux. It draws from and expands upon work from the [Center for Community-Engaged Drug Education, Epidemiology and Research \(CEDEER\)](#) at the UW Addictions, Drug, and Alcohol Institute, including low barrier buprenorphine programs and expressed needs/interests from program participants at SSP surveys.

Low-barrier health engagement “one stop shop” health care and social services are needed for people who use drugs *who are not well served by the current health care system* and experience significant health disparities. Syringe service programs (SSPs) provide a culturally appropriate and trusted setting in which to provide these services in collaboration with participants and regional health care providers/systems and local health jurisdictions. Similar holistic programs to support people living with HIV have been shown to be successful and cost-effective.

In 2019, the Addictions, Drug and Alcohol Institute (ADAI) at the University of Washington launched the “Meds First” program to provide onsite, low-barrier access to buprenorphine in partnership with the six syringe services programs (SSPs) across Washington State. Given that Health Hubs would operate in a similar way, key findings from the Meds First program<sup>26</sup> provide evidence that this could be an effective service for Washington residents who use drugs:

- Care navigation fits flexibly and productively within community-based harm reduction programs
- Participants of harm reduction programs want—and use—care navigation services, especially in-person support
- Providing opioid use disorder treatment with a harm reduction orientation supports honest conversations about drug use

A full report on the Meds First program can be found at [Care Navigation at Harm Reduction Programs \(uw.edu\)](#), and related research findings have been published in *Addiction Science and Clinical Practice*: [“The Community-Based Medication-First program for opioid use disorder: a hybrid implementation study protocol of a rapid access to buprenorphine program in Washington State.”](#)<sup>27</sup>

Additionally, a study published in *Substance Abuse* in 2020<sup>28</sup> found that a low-barrier buprenorphine program co-located with an SSP in Seattle served as an effective point of entry for a low-barrier MOUD program: a large proportion of enrolled patients demonstrated sustained retention and reductions in opioid use, despite housing instability and polysubstance use.

### Concerns and Considerations

- *Concerns related to the workforce demand v. supply to run these Health Hubs*
- *May need to build capacity within SSPs to prepare for this integration; creative partnering needed*

<sup>26</sup> <https://adai.uw.edu/care-navigation-2022/>

<sup>27</sup> [The Community-Based Medication-First program for opioid use disorder: a hybrid implementation study protocol of a rapid access to buprenorphine program in Washington State - PMC \(nih.gov\)](#)

<sup>28</sup> [Engaging an unstably housed population with low-barrier buprenorphine treatment at a syringe services program: Lessons learned from Seattle, Washington - PubMed \(nih.gov\)](#)



- *Additional work will need to be done to determine details pertaining to services billing at these health engagement hubs. Billing for primary care services is often not financially viable except for Federally Qualified Health Centers (FQHCs), and mental health licensure is necessary to receive the higher Medicaid rate for mental health care. If the health hubs cannot be qualified as FQHCs, and licensed mental health clinics, this could put a serious financial strain on the health hubs and jeopardize their sustainability.*
- *Due to the high acuity level of care needed, and because Health Hubs are not Behavioral Health Agencies eligible to bill for withdrawal management services, withdrawal management services have been deemed out of scope for Health Hubs*

### Collaboration with Existing Resources:

- *Suggested Lead Agency: DOH in partnership with UW ADAI and HCA*
- *Partners:*
  - *Syringe Service Programs (SSPs)*
  - *Accountable Communities of Health (ACHs)*
  - *Local Health Jurisdictions (LHJs)*
  - *Federally Qualified Health Centers (FQHCs)*
  - *Community Health Centers (CHCs)*

### Approximate Financial Support and Staffing Needed:

Calculating the financial estimates and overall investment required to stand up these Health Engagement Hubs with sufficient geographic access points will need to be undertaken by fiscal analysts and experts, with due consideration given to the following:

- The number of Health Engagement Hubs needed throughout the state to meet recommendation for one within a 1-2 hour drive of any location in the state
- Staffing needed for each of the domains listed above
- Competitive compensation for staff, to minimize burnout and turnover
- Medical supplies
- Construction costs for any new structures needed
- Vehicles/gas for mobile services
- Projected revenue from billing services

### SURSA Committee feedback

No feedback on this recommendation was provided from SURSAC members during the pre-meeting review period

## Appendix I – Recommendation 8: Employment and education pathways

**Recommendation** – Education and employment pathways, including training, placement, and supported services.

**Bill Requirement(s)** – Section 1.8, Section 4.2(b),(c),(e),(h)

**Background and Supporting Data**

Regional and county-wide programs have been made available to individuals who are seeking employment, education, training/certification, and other supportive resources. Additionally, there are programs provided within the local/county jails for incarcerated individuals to seek and obtain employment upon release. In King County programs like road map to success, Orion industries, and Post Prison Education Program have been able to assist individuals. These programs include, welding certification, entrepreneurship, construction related work, and CDL licensing to name a few. Though there are varied programs available to those with SUD, in recovery, or incarcerated/being released from incarceration, there are still a number of barriers that they individuals experience.

In less dense areas, there are few resources for individuals and there is an all-around barrier of these individuals receiving a livable wage. The stigma of substance use is also a barrier for individuals, making it difficult to obtain employment. Programs like peer support and O-1 intercept interventions should also be able to connect these individuals to the need resources. Include expanding efforts for incorporating individuals incarcerated and released from incarceration into these programs. Current successful models include:

Stone Bridge Re-entry a re-entry service that provides various services for those experiencing poverty, homelessness, incarceration, addiction through community-based services and treatment services.

Brothers United in Leadership Development (B.U.I.L.D) an organization providing services to the black and brown community by developing community partnerships targeting adults and youth to provider leadership and employment, through community groups and services to develop the future generations of leaders.

Programs are also needed that are directed for youth, including community passages for job placement, GED certification, and education pathways through a peer program or mentorship programs. Current successful model, Community Passageways, which is a Seattle based program that has worked with youth that intersect the criminal legal system through community support teams, school-based programs, while using evidence-based interventions to tailor to the needs of youth.

The recommendation creating a grant program to build and sustain community based mental health providers to expand availability of these types of programs with a low barrier one page grant application, targeted for programs that engage with BIPOC and other historically underserved communities. There could also be individual grants or scholarship type program for individuals in recovery housing that includes more than job training but incorporate the cost to get childcare costs covered, drivers licensing testing, transportation, along with cost associated with the training or the training itself.

HCA could create a centralized location for these kinds of resources based on region and resource type for all supportive services, including education and employment.

**Concerns and Considerations** – *What are the potential downsides of implementing this recommendation? Record any dissenting opinions, concerns, or considerations here*

**Collaboration with Existing Resources:**

- **Foundational Community Supports (FCS)**  
FCS provides supportive housing and supported employment services to vulnerable Medicaid beneficiaries by helping participants find and maintain stable housing and employment. Eligibility is determined by risk factors such as chronic homelessness, complex BH and co-occurring SUD, disability, and other long-term care needs.
- HCA is working with peer programs to bring CPC trainings both into Walla Walla and into Mission Creek, to train folks to become CPC's.

**Approximate Financial Support and Staffing Needed:**

Dollars	CY23	CY24	CY25
<b>Legislative / State Budget Funding</b>	440,000 grant funding for a biennium		225,000 maintenance funding
<b>HCA Grant-Based Funding</b>			
<b>Total Funds</b>			
<b>Staff (FTE)</b>	1	1	1

**SURSA committee feedback**

No feedback on this recommendation was provided from SURSAC members during the pre-meeting review period

## Appendix J – Recommendation 9: Expansion of WHRL and Asset Mapping

**Recommendation** – *Expansion of the WA Recovery Helpline and the Recovery Readiness Asset Tool to provide a robust resource database for those seeking or directing to services.*

**Bill Requirement(s)** – *5476 Section 1.3 (a),(b),(c),(d),(e),(f),and (g)*

### **Background and Supporting Data:**

Providing a tool that maps and directs individuals to community-based care access points, along with safe station entities with a tool that helps locate and help those currently in need of outreach, treatment, and recovery support services is vital to the requirements and plays the role as an assistive tool to meet other items outlined in section 3 of RCW [71.24.546](#), as part of the Blake Bill(ESB 5476). By expanding upon the current recovery readiness asset tool (this does not indicate an individual’s readiness to enter recovery) built from the Roadmap to Recovery and the WA Recovery Helpline, we can enhance the capabilities of the tools available to reach more Washingtonians affected by SUD and their families. This tool will work in conjunction with the E2SHB 1477 work to designate a primary technology system to provide “Real-time bed availability for all behavioral health bed types, including but not limited to crisis stabilization services, triage facilities, psychiatric inpatient, substance use disorder inpatient, withdrawal management, peer-run respite centers, and crisis respite services, inclusive of both voluntary and involuntary beds, for use by crisis response workers, first responders, health care providers, emergency departments, and individuals in crisis.”

This Committee also recommends a referral system to be incorporated with the locator tool to help facilitate the connection between an individual and a facility to address capacity concerns.

Local counties like King County have developed county specific resources, Emerald City Resource Guide by Real Change: [Emerald City Resource Guide](#). WA211 provides community resources [Home - Washington 2-1-1 - WA 2-1-1 \(wa211.org\)](#) MOUD resource finder helps people connect to medications [MOUD Locator - Washington Recovery Help Line \(warecoveryhelpline.org\)](#) and DOH is releasing resource finder that utilizes WA211 data for a resource finder specifically for substance use during pregnancy and for parents. DOH is working to create a data system that holds all of the data for the different resource finders, so they are kept current and have all the same data. HCA has a number of resources including a [pamphlet](#) of integrated behavioral health community resources and DOH Green book.

Beyond providing treatment and recovery support service locations, this database should also include the community-based resources, including locations for SSPs, peer and care navigators, opioid treatment network care partners (hub and spoke), and RNP community resources. This tool should also consider including infectious disease services that are systemic to the overdose crisis (e.g., hepatitis C services). Creating a more robust system to include civil legal, and welfare locations as well, will provide a better full continuum of care for individuals in an easily accessible way. DCYF is currently working toward a similar grassroots map for their child welfare and family resources regarding SUD and recovery support services. There are several legal systems throughout the state that have similar maps that also provide legal resources for those impacted by SUD. To eventually gather and include those various groups would make this the most robust resource system available to date.

Other states including [Kentucky](#), and even local jurisdictions such as [Spokane County](#) have similar tools that have proven to be effective in their geographical regions and we would like to expand these types of tools across Washington State.

Foundation infrastructure is key to providing the most up to date services and resources according to Third Horizons and Atlas Shatter Proof, who already have been contacted to quote on similar work being done. Pipelines are created from existing and future data sources to a single system to provide the locator and referral tools as described above. This creates real-time updated systems. To ensure data streams are updated regularly by the information provider, legislative mandates shall be imposed to enforce the need for updated data. The proposed expansion of the MOUD locator and recovery readiness asset tool includes the development of a larger database of resource and a dual interface program, one for the public and one for internal use. These two interfaces include, and external page made to public including crisis stabilization, care access points, and families with a mapping tool, and asset list. The internal interface will have tools for HCA staff, MCO provider networks, and policy makers including, dashboards, gap analysis tools, regional capacity, and workforce checklists.

Pipelines to current and future data tables, that should be incorporated within the system are:

- RDA Data/Geo data from ProviderOne
- DOH Licensure data
- Recovery Helpline data
- Grant and other non-Medicaid care access points (opioid treatment network care partners, syringe services, etc.)
- DCYF available data

Campaigning and advertising for Recovery Helpline is a crucial component for educating the public on the helpline and tools, along with indicating its intent as opposed to a crisis hotline.

Along with additional resources for a heartier system, the WA Recovery Helpline will need non-clinical, people with lived experience, full-time employees (FTEs) to support this expansion work on the database and to meet the growing demands the Recovery Helpline will experience.

**Concerns and Considerations –**

Displaying accurate information regarding billing location as opposed to service location for providers. A quality assurance process should be developed and incorporated into the system.

**Collaboration with Existing Resources:**

**Recovery Helpline**

Provides MOUD locator resources through the hotline and website on a google maps platform. This information is updated monthly and manually by recovery helpline staff. This information would play into resources that may not be directly connected to Medicaid and the ProviderOne data and will be kept current by staff and shared to make sure geolocations are being updated properly.

**988/SB 1477**

Establishes crisis call center hubs and an expanded response system for those experience mental health and suicide. It proposes to create technology and platforms necessary to manage and operate the behavioral health crisis response and a suicide prevention system. This system is currently be worked through the Department of Health data before being handed over the authority. This system will have a similar type of map or list of resources to submit individuals to services through a referral mechanism.

## SUBSTANCE USE AND RECOVERY SERVICES PLAN

This tool will be helpful to ensure the current connection to behavioral health services is similar with SUD and co-occurring mental health conditions.

### Approximate Financial Support and Staffing Needed:

Dollars	FY23	FY24	FY25
<b>Legislative / State Budget Funding</b>	\$1,000,000/System Development \$1,000,000/Campaign/Ads	\$360,000/System Maintenance	\$360,000/System Maintenance
<b>HCA Grant-Based Funding</b>			
<b>Total Funds</b>			
<b>Staff (FTE)</b>	8	6	6

Estimations are based off previous quotes from technical developers, along with adding more funding for referral technology and required FTEs to support education, training, and technical assistance.

Substantial staffing will be need for this to do this dynamically. The above numbers are minimalistic and there will most likely be greater need for more FTEs to uphold system throughout the various agencies consistently providing resources.

### SURSA committee feedback

From Sarah Melfi-Klein: received September 15, 2022 –

**Q:** Would this plan include mapping for Tribal-specific recovery resources as well or as a parallel to this work?

**A:** This is entirely dependent on willingness and participation to provide local resources.

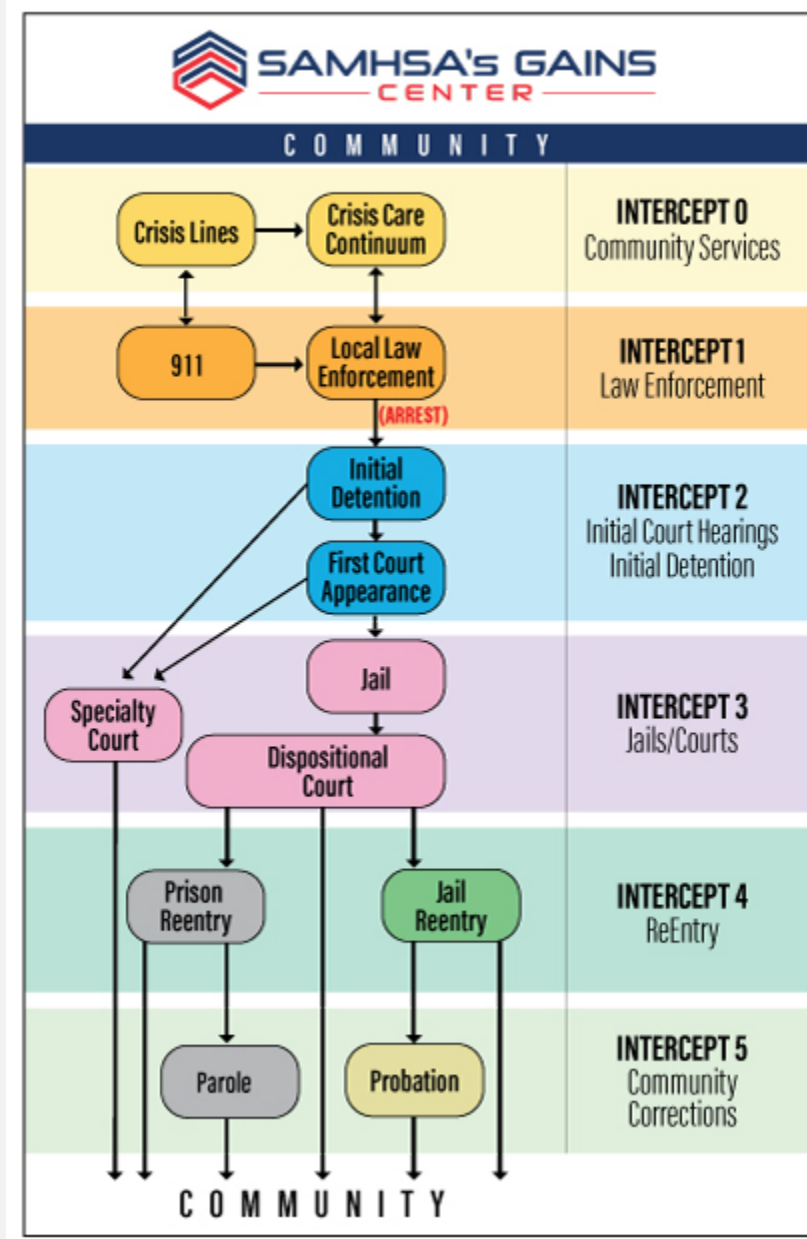
From Caleb Banta-Green: received September 16, 2022 –

**Q:** Is there possibility of the database being part of a closed loop referral database so that RHL collected data are provided to downstream referrals and so RHL gets feedback on client flow to improve their processes?

**A:** Recovery Help Line does not collect data beyond general demographics. We want to continue to provide that anonymity to individuals seeking services.

Appendix K – Recommendation 10: Expanding investment in programs along the 0-1 intercept on the sequential intercept model

**Recommendation** – Continue and further increase investment in evidence-based diversion programs that operate along intercepts 0 and 1 on the sequential intercept model, including, but not limited to, the Recovery Navigator Program, Arrest/Jail Alternative programs, LEAD, and other harm reduction, trauma-informed, and public health-based approaches, especially programs and interventions that center a racial justice lens; and amend [RCW 10.31.110 \(Alternatives to Arrest – Individuals with mental disorders or substance use disorders\)](#) and [RCW 10.31.115 \(Drug Possession – Referral to assessment and services\)](#) to reflect how these programs should be used as part of a statewide arrest and jail diversion system by mandating availability of services within a supportive network of care. Proposing state, regions, and counties to provide proportionate and adequate funding as supplied into the criminal legal system.





To provide services, outlined below, to the Washington youth population the request was made to provide adequate policy changes to address the youth barrier, and CMS State Plan Amendment, for services made available to youth starting at the age of 13, the minimum Medicaid enrollee age without an adult, and incorporate MAT accessibility and coverage.

Consistent with the Plan requirement outlined in ESB 5476 Section 1.3(i), this recommendation requests shifting funding to increase and sustain investments to ensure equitable distribution of, and access to, culturally appropriate, non-punitive, community-based resources, including treatment.

A range of services are noted as diversion options in 10.31.110, and each of these should be made available in all regions – at least one in every BH-ASO at a minimum -- so that when law enforcement officers make referrals within their jurisdictions as part of the arrest and jail alternatives / diversion strategies, those referrals are met with a range of available behavioral health options to best meet the needs of the individual who has been diverted from legal system involvement.

Those services are:

- **Crisis stabilization units for youth and adults**, as defined in RCW 71.05.020 – “A short-term facility or a portion of a facility licensed or certified by the department, such as an evaluation and treatment facility or a hospital, which has been designed to assess, diagnose, and treat individuals experiencing an acute crisis without the use of long-term hospitalization” -- at which the individual must be examined by a mental health professional or substance use disorder professional within 3 hours of arrival
- **Triage facilities for youth and adults**, as defined in RCW 71.050.020 – “A short-term facility or a portion of a facility licensed or certified by the department, which is designed as a facility to assess and stabilize an individual or determine the need for involuntary commitment of an individual and must meet department residential treatment facility standards. A triage facility may be structured as a voluntary or involuntary placement facility”
- **Designated 24/7 crisis responders** for evaluation for initial detention and proceeding under 71.05 RCW
- **Mobile crisis response services for youth and adults**
- **Regional entities responsible for receiving referrals** in lieu of legal system involvement, such as Recovery Navigator Program

In addition, these services should be made available in all regions as well:

- **ASAM-alternative SUD Assessments (15 mins max) for youth and adults** (contingent on assessment recommendation approval)
- **Syringe Service Programs for youth and adults**
- **Health Hubs for youth and adults who use drugs** (contingent on Health Hub recommendation approval)
- **Detox/Withdrawal management for youth and adults**
- **MOUD (Suboxone) for youth and adults**
- **Outpatient treatment for youth and adults**
- **Ensure that long-term harm reduction supported case management is available after diversion so that diversion becomes meaningful**

**Bill Requirement(s)** – This recommendation directly addresses 5476 Section 1.3:

*“(g)Framework and design assistance for jurisdictions to assist in compliance with the requirements of RCW 10.31.110 for diversion of individuals with complex or co-occurring behavioral health conditions to community-based care whenever possible and appropriate, and identifying resource gaps that impede jurisdictions in fully realizing the potential impact of this approach.”*

*“(i)The proposal of a funding framework in which, over time, resources are shifted from punishment sectors to community-based care interventions such that community-based care becomes the primary strategy for addressing and resolving public order issues related to behavioral health conditions;”*

**Youth:** As more services for youth are available, RNP services will be directing youth into those services

**Rural Areas:** This funding will expand RNP programs in rural areas

**Tribes:** The subcommittee recognizes that each tribe are sovereign entities and will not impose requirements for RNP or diversion programs but would like to extend equal funding to provide these types of resources within their tribe. Each tribe would get the option to participate or establish their own diversion programs, or expand existing programs, and would get proportional investment as any BH-ASO/region, regardless of participation in or collaboration with local region BH-ASO RNP program.

### **Background and Supporting Data**

Specific models like LEAD and other evidence-based, public health, and harm reduction approaches have been effective but under-utilized in Washington State. Interventions that are outreach-based and that operate on a shared decision-making model, offering low-barrier engagement and trust-building relationships with clients deserve more investment and support. The emphasis among these interventions should target the zero and one locations on the sequential intercept model.

The Recovery Navigator Program is receiving \$25 million in 2022, and \$20 million in 2023, from the general-state fund to initiate and implement recovery service navigation in each of the 10 Behavioral Health Administrative Service Organizations throughout Washington State. However, these programs will need more than two years of funding to establish trust within communities and demonstrate efficacy as an alternative to a criminal-legal approach to substance use in communities, and increased annual funding is needed to expand services in BH-ASOs that cover multiple counties with rural areas that would also benefit from transportation services.

### **Concerns and Considerations**

- Some concern was expressed that money would continue to flow to programs without a system for accountability around outcomes, and that money should be withheld if the programs are not generating desired results

### **Collaboration with Existing Resources:**

- ❖ Arrest and Jail Alternatives (AJA), per [HB 1767](#), [RCW 36.28A.450](#)

## SUBSTANCE USE AND RECOVERY SERVICES PLAN

- ❖ LEAD Pilot Project, per [5380 Section 29, RCW 71.24.589](#)
- ❖ Recovery Navigator Program, per 5476, [RCW 71.24.115](#)
- ❖ Federal COSSAP funds

### Approximate Financial Support and Staffing Needed

*The Recovery Navigator Program is receiving \$25 million in 2022 and \$20 million in 2023 from the general-state fund*

- ❖ *Look at funds provided to BH-ASOs for RNP for program estimates*
- ❖ *Settlement funds are also a potential source of funding*
- ❖ *Allocating funding through RNP for transportation needs based on regional needs and capacity. To including purchasing vehicles, contracting local public transportation services, and per mile reimbursements.*

### **Financial Impact: Recovery Navigator Program**

Dollars	FY23	FY24	FY25
<b>5476 Funding</b>	\$20 million general-state fund Additional 25 M	\$20 million general-state fund Additional 25 M**	\$20 million general-state fund Additional 25 M**
<b>HCA Grant-Based Funding</b>			
<b>Total Funds</b>			
<b>Staff (FTE)</b>	0	0	0

**\*\*incremental increasing over the years for increased services, increased population, outcomes**

### **Financial Impact: Arrest and Jail Alternatives and LEAD Expansion**

NOTE: Decision Package has been submitted to expand this program

Dollars	FY23	FY24	FY25
<b>General State Funding</b>	\$4,300,000	\$4,300,000	\$4,300,000
<b>Grant Funding</b>			
<b>Total Funds</b>			
<b>Staff (FTE)</b>	0	0	0

### **SURSA committee feedback**

No feedback on this recommendation was provided from SURSAC members during the pre-meeting review period

## Appendix L – Recommendation 11: SUD engagement and measurement process

**Recommendation for a new SUD engagement and measurement process**

Because Substance Use Disorder (SUD) is chronic and potentially acutely life-threatening:

- Care for people with SUD needs to be accessible and initiated as quickly as possible.
- Care for people with SUD needs to be accessible in places and care settings that are low barrier/crisis oriented (e.g., Health hubs for people who use drugs (PWUD), Emergency departments, CHC/FQHC) in addition to care settings such as withdrawal management and specialty SUD treatment.
- The initial engagement and measurement process should be focused on what is minimally necessary to document a diagnosis, determine medical necessity and start care the same day and be conducted in less than 15 minutes:
  - This could include brief screening, diagnosis, documentation of a person’s care preferences, and if the client wants, initial discussion about the level of care/care setting or lead to a full assessment.
- Initial engagement and SUD measurement must be focused on, and limited to, client’s needs and should be limited to only the necessary domains. Trauma and culturally informed approaches must be taken in terms of the total time, content, and process of engagement and measurement.

We ask that:

- The Washington State Health Care Authority (HCA) convene a workgroup who will review current processes and workforce needs related to intake, screening, and assessment for SUD services,
- HCA determine how to build an SUD engagement and measurement process including developing any necessary rules and payment mechanisms,
- HCA work with PWUD, care providers, state regulators, and payors to address this recommendation within 12 months, and,
- In the interim, any work that HCA can undertake to advance these goals should be done.

**Initial engagement and measurement goals:**

- Be as brief as possible and only what is necessary to initiate care the same day whenever possible, typically less than 15 minutes.
- Be available on demand whether in person or virtually at centralized and accessible community access points.
- Be available in diverse health care, behavioral health, emergency, and SUD settings.
- Be available within four hours of request 8am-8pm and within 12- hours 8pm-8am.
- Be culturally appropriate and trauma informed.<sup>29</sup>
- Consider the patient’s self-identified needs and preferences when evaluating direction of treatment and/or referral to services.

<sup>29</sup> <https://www.hca.wa.gov/about-hca/trauma-informed-approach-tia>  
<https://www.hca.wa.gov/about-hca/who-we-are/health-equity>

- Eliminate financial barriers to accessing immediate and individualized services.
- Be administered by a range of health professionals, guided by the scope of practice of a service provider.
- Assessments should be conducted if only necessary and not more than one per 12-month period.<sup>30</sup>

**Bill Requirement(s)** – *Low barrier, person-centered care should be informed by people with lived experience.*

Reducing the time required during initial assessments to center on the self-identified need and desire for care that guide the direction of treatment, harm reduction services, recovery supports, and other necessary services based on the needs identified by the client and for the Plan to assist persons with timely access to all services, including treatment.

### Defining Terms

**Intake:** There is no definition for intake established within WAC or RCW. For the purposes of this recommendation, intake would be the process through which an individual gains access to behavioral health services and the associated subprocesses, forms, and declarations associated with that process. This includes the administration of screening tools and assessments done to diagnose and determine medical necessity.

**Screening:** Per [RCW 71.24.630](#), HCA is directed to maintain an integrated and comprehensive screening and assessment process for substance use and mental health disorders. Under this section, the process shall include an initial screening tool which can be used by intake personnel systemwide and which will identify the most common types of co-occurring disorders, and through screening, identify triggers which would indicate the need to begin an assessment. This could include utilization of screening tools like the GAIN-SS, AUDIT, DAST, ASSIST, etc.

**Assessment:** Per [WAC 246-341-0200](#) "Assessment" means the process of obtaining all pertinent biopsychosocial information, as identified by the individual, and family and collateral sources, for determining a diagnosis and to plan individualized services and supports. Per [WAC 246-341-0460](#), the Clinical Record must include "an assessment which is an age-appropriate, strengths-based psychosocial assessment that considers current needs and the individual's relevant behavioral and physical health history according to best practices, completed by a person appropriately credentialed or qualified to provide the type of assessment pertaining to the service(s) being sought, which includes: a diagnostic assessment statement, including sufficient information to determine a diagnosis supported by the current and applicable Diagnostic and Statistical Manual of Mental Disorders (DSM-5) or a placement decision, using ASAM criteria dimensions, when the assessment indicates the individual is in need of substance use disorder services.

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<sup>30</sup> Per the HCA Service Encounter Reporting Instructions, "a new assessment evaluation is not required if an assessment was completed in the 12 months prior to the current request and medical necessity was established. The previously completed assessment may be used to authorize care."

HCA's [Service Encounter Reporting Instructions](#) (SERI), which provides Apple Health Managed Care Organizations (MCO) and the Behavioral Health Administrative Services Organizations (BH-ASO) in integrated care regions, and all BH providers in licensed community mental health clinics/licensed behavioral health agencies assistance for reporting behavioral health service encounters, indicates that Assessment services are defined as "The activities conducted to evaluate an individual to determine if the individual has a substance use disorder and determine placement in accordance with the American Society of Addiction Medicine (ASAM) criteria."

*Medical Necessity:* According to [WAC 182-500-7010](#), "medically necessary" or "medical necessity," with regard to substance use disorder, is defined by the most recent version of the *ASAM Criteria, Treatment Criteria for Addictive, Substance Related, and Co-Occurring Conditions* as published by the American Society of Addiction Medicine (ASAM). Based on [WAC 182-500-0070](#), "medically necessary" is a term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purposes of this section, "course of treatment" may include mere observation or, where appropriate, no medical treatment at all.

### **Background and Supporting Data**

Access to timely SUD assessments varies widely across Washington State. In urban areas, people seeking or needing an assessment may go to drop-in hours multiple times over several weeks before they obtain an assessment. In rural areas there may be a single provider currently allowed to do assessments and they may have a multi-week wait list. Alternatively, in some care settings all that is needed to initiate care is an SUD diagnosis, e.g., a medical clinic with a licensed prescribing provider onsite. The variable access to care by geography, provider types, and care settings is an example of state and federal rules and regulations negatively impacting equitable access to care.

The ASAM Criteria is the most widely used and comprehensive set of guidelines for placement, continued stay, transfer, or discharge of patients with addiction. Other tools, some used in the mental health system or by Managed Care include the LOCUS, CALOCUS, InterQual, and Milliman. Although ASAM as a biopsychosocial assessment is not specifically required in a State Plan Amendment for Medicaid, it is mentioned in Washington State's 1115 Medicaid Waiver. ASAM is also a requirement in HCA policy (the [SUD Fee-for-Service Billing Guide](#)) and [WAC 246-341-0640, "Clinical record content."](#) This policy is in place to ensure sufficient information to guide placement decisions when the assessment indicates the individual is in need of substance use disorder services.

The shorter engagement and measurement processes proposed in this recommendation can therefore be used to demonstrate medical necessity for any level of behavioral health care / SUD treatment placement, as long as they include questions that align with the ASAM criteria needed for the health plan's utilization review team to apply ASAM to assess medical necessity in order for the service provider to receive reimbursement for services provided.

However, while the DSM-5 criteria for substance use disorder is composed of 11 yes/no questions, the [ASAM Criteria Assessment Interview Guide](#) is 31 pages long, takes the average clinician about 90 minutes to complete, and covers six dimensions of assessment (Acute Intoxication and/or Withdrawal Potential, Biomedical Conditions and Complications, Emotional, Behavioral or Cognitive Conditions and Complications, Readiness to Change, Relapse, Continued Use or Continued Problem Potential, and Recovery and Living Environment) intended to identify optimal treatment placement for an individual. It is typical for individuals who come into contact with providers to have well documented needs, numerous system encounters and history of assessments and admissions, and ample documentation of necessity and diagnosis.

The volume of questions, the speed at which they are administered, and the potential personal trauma from highly sensitive questions (many unrelated to immediate care needs) are all potential reasons for people to avoid participating in these lengthy assessments, which then becomes a barrier to accessing treatment services.

Moreover, someone undergoing an SUD assessment may be under the influence of substances and are not in an appropriate frame of mind to be answering so many personal questions; people need the opportunity to stabilize / allow their spirit to return to their bodies before engaging in the longer assessments.

There is usually a small window of readiness when a person with a substance use disorder is ready and willing to engage in treatment and recovery services, and a lengthy assessment process not only does not guarantee treatment access, but it can also often lead to frustration, and eventually deter someone from pursuing treatment and recovery. Neither ASAM nor SAMHSA guidelines should be interpreted or used as a standard of care or specifically required by Washington State agencies.

The ability to do an assessment should be guided by the scope of practice of a service provider and not be limited to a single and specific credential in certain settings (e.g., SUDP), as it is currently. For example, a hospital setting should not need an SUDP to complete an assessment that is reasonably in the scope of practice of another provider. A solution could include the capturing of necessary information by trained professionals with supervision and oversight by credentialed practitioners, so that a shortage of SUDPs at a given facility does not impede someone seeking SUD services from receiving an urgently needed assessment

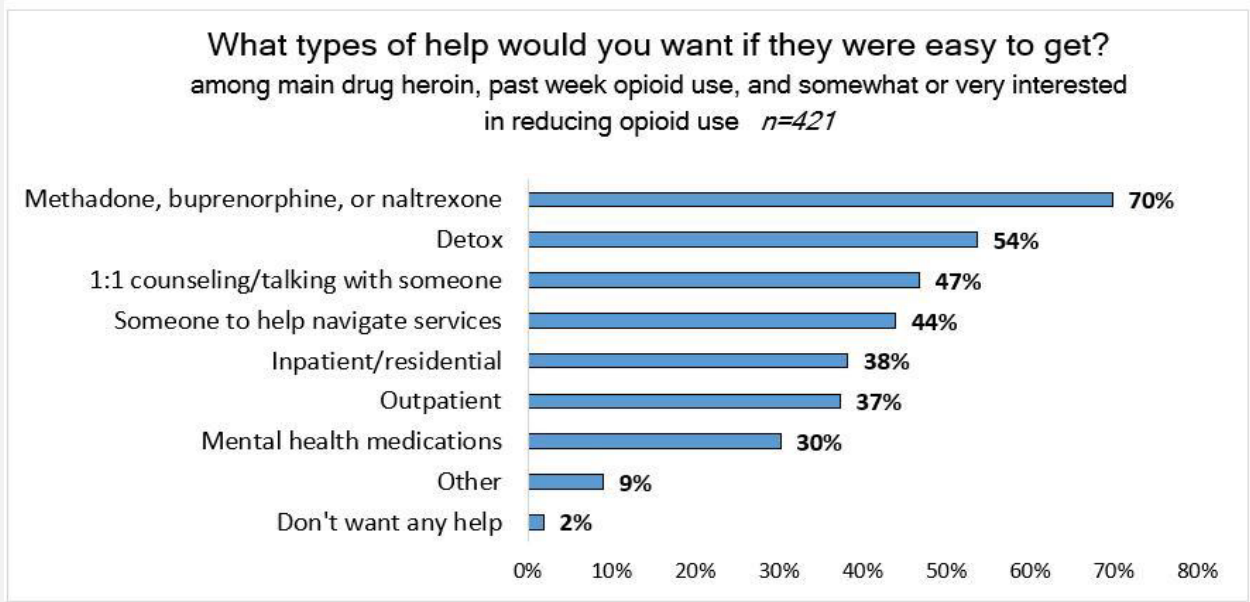
**Ease of access improves engagement with services:** According to the 2019 results of the Washington State Syringe Exchange Health Survey<sup>31</sup>, among opioid users who had used opioids in the past week (mainly heroin) and were somewhat or very interested in reducing their opioid use, most of them would want methadone, buprenorphine, or naltrexone (70%) and withdrawal management services (54%) if those services were easy to get (see graph from the report below). Low barrier treatment programs,

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<sup>31</sup> [WA State Syringe Exchange Health Survey, 2019 Results | Addictions, Drug & Alcohol Institute \(uw.edu\)](#)



informed by these clients' preferences, utilizing buprenorphine at harm reduction programs found high client uptake and engagement<sup>32</sup>.



Concerns and Considerations

- Role of SUDPs:** Providing ASAM Criteria assessments is a significant aspect of the roles of Substance Use Disorder Professionals (SUDPs). If these assessments are no longer used or needed prior to initiating SUD care, it could reduce the demand for SUDPs and have a detrimental impact on their employment opportunities and SUD agency financial viability. SUDPs are vital contributors in the behavioral health workforce, and we want to ensure their role in providing evidence-based care going forward. Their value extends beyond the ability to do assessments and it is important to support their ability to do more valuable work to support people with SUD including assessment, addiction counseling, case management and care navigation. However, there is no existing requirement for the service provider to conduct an ASAM-specific assessment, if the patient's health plan can use information from the assessing provider to apply ASAM criteria themselves. For higher acuity needs like withdrawal management, full ASAM structure for assessments are not always needed, if the member meets criteria in ASAM dimension 1 (acute intoxication/withdrawal potential) to medically authorize withdrawal management in those cases.
- Maintaining objectivity:** Shorter assessments that do not use ASAM criteria and the specific decision pathways it provides may increase risk of subjectivity and bias in the assessment process.
- Demonstrating "Medical necessity" based on level of care needed:** There is a "medical necessity" clause to receive money/be paid for services, depending on the type of care needed.

<sup>32</sup> [Care Navigation at Harm Reduction Programs: Community-Based "Meds First" Buprenorphine Program Preliminary Data. | Addictions, Drug & Alcohol Institute \(uw.edu\)](#)

**Regulatory and financial implications:** The Treatment subcommittee recognizes that there are regulatory and financial implications of replacing the ASAM with a shorter version of SUD Assessment, such as determining whether and how the shorter assessments will be billed; such details will need to be sorted out within HCA/DBHR.

- **Multiple diagnoses and medical necessity:** Often, what providers deliver in terms of care and services are supportive interventions to address symptoms and behaviors. These symptoms and behaviors are related to any number of diagnoses a client has, and they do meet medical necessity. Additionally, there are many records and assessments that tell us that. Our current rules and coding guidelines are precise and restrictive in ways that prevents access. The goal here is to expand access and allow for interventions to be delivered by qualified professionals. A consulting SUDP can provide the additional training, consultation, and record oversight.
- **Reimbursement parity needed between SUD and MH:** We have bifurcated BH treatment into MH and SUD modalities but when treating symptoms and behaviors we should consider the value of interventions traditional in the MH system, like CBT, DBT. There is not parity in reimbursement in SUD system and contracting and credentialing make it challenging to access services in one system rather than another. An integrated system would consider the interventions for symptoms and behaviors rather than diagnosis. In other words, know our population, align with the right services, and support access to additional interventions you are not able to provide.

**Collaboration with Existing Resources:**

- ❖ *Community partners: Collaborate with workforce efforts at two and four year higher education schools. Coordinate with other behavioral health workforce efforts including those underway at the UW’s Behavioral Health Institute.*

**Approximate Financial Support and Staffing Needed:**

Dollars	FY23	FY24	FY25
Legislative / State Budget Funding	140,000	140,000	140,000
HCA Grant-Based Funding			
Total Funds			
Staff (FTE)	1	1	1

**SURSA Committee feedback**

No feedback on this recommendation was provided from SURSAC members during the pre-meeting review period

Appendix M – Recommendation 12: Stigma-reducing outreach and education, more importantly regarding youth and schools

**Recommendation** – *Provide education related to naloxone administration and overdose identification in Washington State public schools (grade 6<sup>th</sup> – 12<sup>th</sup>) to reduce stigma and save lives. Intended audience for this recommendation includes students, administrators, teachers, and other educational professionals.*

**Bill Requirement(s)** – *ESB 5476 section 1.3 (a)*

**Consideration of youth, rural areas, and tribes:**

**Youth:** Youth in 5<sup>th</sup> grade and older would receive this stigma-reducing outreach and education

**Rural Areas:** Schools across the state, including rural areas, would receive this stigma-reducing outreach and education

**Tribes:** Support existing stigma-reducing campaigns among tribes

**Background and Supporting Data**

Youth and Young Adults are overrepresented in substance use related mortality. Surveillance from the Washington State Department of Health highlighted between 2019 to 2020, there was a 59% increase in the number of drug overdose deaths among persons aged 24 and under, compared to the overall population (all ages) an increase of 37.5%. The increase between 2020 to 2021 for the 24 and under was 9.8%.

With the dramatic increase in substance use mortality, it is imperative to improve response to overdose and education among drug use with youth and young adults. This may be achieved through practical strategies including, but not limited to naloxone distribution within school settings, overdose education, evidenced-based drug safety curriculum starting at the 6<sup>th</sup> grade, and partnerships with other community organizations that advance the health and well-being of young people.

Learning curriculums for young people that are evidenced based include [Safety First](#).

Additionally, strong partnerships must be developed within the educational system ranging from employers, tribal school boards, local districts, students, and the state to maximum practice and procedure.

[RCW 69.50.412: Prohibited acts: E—Penalties. \(wa.gov\)](#) prohibits the distribution of a hypodermic syringes to persons under the age of 18. This RCW prohibits entities and/or individuals from distributing intramuscular syringes needed for naloxone administration. Intramuscular naloxone is currently substantially cheaper than nasal formulations – being limited by cost and access of naloxone due to RCWs may exacerbate any disparities of substance use mortality among persons under the age of 18. This law will need a technical amendment to remove barriers to life saving medication.

Stocking a “standing order” (as defined in [RCW 69.41.095](#)) of “opioid overdose reversal medication” (e.g., Naloxone) is required via [RCW 28a.210.390](#) to be stocked in high schools (grades 9-12) already for school districts with more than 2,000 students. These medications can be administered by a school nurse, a health care professional, or trained staff person located at a health care clinic on public school property under contract with the school district, or designed trained school personnel. The opioid overdose

reversal medication may be used on school property, including the school building, playground, or school bus, as well as during field trips or sanctioned excursions away from school property.

Funding would need to be provided to increase naloxone and overdose education among school aged young people (6<sup>th</sup> grade – 12<sup>th</sup> grade), which includes funds related to outreach and communication. Concerns are related to state authority to standardize this work. While the state does play a role, the decision to implement these activities will belong to the local school districts.

This recommendation shall allow the stocking of naloxone at schools to be used in the event of an overdose and allow school health staff to provide naloxone to students upon request in a confidential manner.

Concerns and Considerations –

- If schools begin distributing Naloxone for use outside of schools, principals and superintendents may come under fire/receive pushback from community. They would likely advise to find another way to get naloxone to kids outside of schools, such as non-school clubs or athletics. Another option would be to allow option for parents to opt in/opt out for their child’s participation in such a distribution program
- Schools are inundated with extra/additional curriculum requests, and they are already behind on executing the required curriculum from RCW (to create time to administer a new curriculum longer than 30 minutes, would need to extend the school day). For this reason, finding ways to weave *essential, actionable* information into existing curriculum could be more realistic. For example, the topic of drug use and a short naloxone administration demonstration could be integrated into existing social-emotional curriculum, as drug use is commonly a form of emotional self-regulation/self-soothing.
- Alternate ways of promoting educational/informational messages should be explored that do not require the schools to add to their curriculum (e.g., social media, paid media, etc.)
- Stakeholder opportunities with parents and custodians would be needed for the implementation of this recommendation.

Collaboration with Existing Resources: *Potential collaborating partners and stakeholders include:*

- ❖ *School Districts/ School boards*
- ❖ *Washington Office of Superintendent of Public Instruction (OSPI)*
- ❖ *Washington State Dept of Health Overdose Education/Naloxone Distribution Program*
- ❖ *Washington State Health Care Authority Overdose Reversal Medication Program (SB 5195)*
- ❖ *Stigma-reducing campaigns for tribes, such as [ONE](#)*
- ❖ *Local tribal districts*
- ❖ *UW ADAI*

**Approximate Financial Support and Staffing Needed:**

There are approximately 500,000 students in Washington in grades 6-12. Stocking enough naloxone in each school for approximately 10% of students at a time (50,000) – with a clear process for ordering more as needed -- would cost about \$2.75 million dollars.

Funding related to outreach/communication strategies must be allocated in the amount of \$5 million.

Funds will be evenly distributed to each local school district.

Additionally, funding for FTE at the department will be allocated in the amount of \$200,000 – funds will cover administrative and data components of naloxone distribution, utilization, and technical assistance.

### **SURSA Committee feedback**

No feedback on this recommendation was provided from SURSAC members during the pre-meeting review period

Appendix N – Recommendation 13: Law Enforcement and Behavioral Health data collection  
**Recommendation** – Build upon, and provide ongoing funding for, a data integration infrastructure that can receive and analyze standardized data gathered by law enforcement, courts, and prosecutors; Recovery Navigator Program case management; behavioral health treatment services; and recovery support services, to meet the mandates of Section 1.3(m).

**Bill Requirement(s)** – Per Section 1.3(m), this is a recommendation “regarding the collection and reporting of data that identifies the number of persons law enforcement officers and prosecutors engage related to drug possession and disparities across geographic areas, race, ethnicity, gender, age, sexual orientation, and income. The recommendations shall include, but are not limited to, the number and rate of persons who are diverted from charges to recovery navigator services or other services, who receive services and what type of services, who are charged with simple possession, and who are taken into custody.”

**Background and Supporting Data**

- The focus in this recommendation is on a general data infrastructure for *reporting* key indicators. This may have substantial overlap with the data infrastructure required to *administer* diversion and the RNP program, including tracking of prior diversions throughout the state as required by law.
- Data is being collected in various sectors and programs related to substance use and behavioral health systems (law enforcement encounters, treatment, recovery support services programs, Recovery Navigator Program, etc.)
- Many of those data systems do not have a consistent identifier across systems, or consistent standards for data collection and classification, which creates redundancies and makes it difficult to link the data between sectors. This hinders understanding of the patterns taking place among different communities and their outcomes following an encounter with law enforcement.
- Consistent data gathering and integration methodologies such as those described in this recommendation would meet the data mandates of 1.3(m)
- A data integration infrastructure such as the one described in this recommendation has been implemented in four LEAD pilot sites per [RCW 71.24.589](#) (Whatcom, Snohomish, Mason, and Thurston counties) and three [Arrest and Jail Alternatives](#) grantee sites per [RCW 36.238A.450](#) (Olympia, Port Angeles, Walla Walla).

The data integration infrastructure should be able to gather, share, and report, at a minimum, the following data elements, most of which are required per 5476 §1.3(m):

Data element	Potential Source(s)	Mandated per 5476
The number and demographic information of incidents and unduplicated persons engaged by law enforcement officers on diversion-eligible charges.	Law Enforcement Records Management	YES

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<p>The number and percentage of persons engaged by LE on diversion-eligible charges who are arrested, released, or diverted from charges via referral to <b>recovery navigator services</b>, along with the demographics of both those stopped and those diverted</p> <p>("Diversion utilization percentage" is a measure of outcomes of all potential diversions)</p>		<p>Law Enforcement Records Management</p> <p>Case management records</p>	<p>YES</p>
<p>The number, percentage, and demographics of diversion-eligible persons engaged by LE who are diverted from charges via referral to <b>RNP or other services</b></p>		<p>Law Enforcement Records Management</p>	<p>YES</p>
<p>The number and demographics of diverted people who <b>complete enrollment</b> in RNP</p>		<p>RNP Case Management</p>	<p>YES</p>
<p>The number of persons receiving RNP <b>intensive case management</b> through RNP</p>		<p>RNP Case Management</p>	
<p>The number of persons enrolled in RNP who have received any SUD treatment and/or other support services</p>		<p>Datasets from SUD treatment and recovery support services programs (many services would not be captured in claims data)</p> <p>Provider One</p> <p>RNP Case Management</p>	<p>YES</p>
<p>If simple possession remains categorized as criminal activity:</p>	<p>Of those arrested for simple possession, the number, rate, and demographics of persons charged/prosecuted for simple possession</p>	<p>Prosecutors' Offices / AOC</p> <p>Washington State Courts</p> <p>Judicial Information System</p>	<p>YES</p>
	<p>Of those arrested for simple possession, the number, demographics, and rate of persons booked into jail with charge of simple possession</p>	<p>Jail records</p> <p>WASPC/Provider One</p> <p>Washington State Patrol (arrest records)</p>	<p>YES</p>
	<p>Of those arrested for simple possession, the number, demographics, and rate of persons offered post-arrest diversion</p>	<p>Prosecutors' Offices / AOC</p> <p>Washington State Courts</p> <p>Judicial Information System</p>	
	<p>Of those arrested for simple possession, the number, demographics, and rate of persons</p>	<p>Prosecutors' Offices / AOC</p> <p>Washington State Courts</p> <p>Judicial Information System</p>	



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	receiving case disposition, including, but not limited to, conviction		
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In addition to the data above, the following data should be collected and reported using this data integration infrastructure for inclusion in the Recovery Navigator Quarterly Reports from HCA:

### System utilization

- Use of emergency medical services
- Arrest, days in jail
- **New charges** with incident date after of referral to RNP (divided by felony, misdemeanor), to be added to Case Management tab in RNP Data Collection tool
- **Convictions** with incident date after date of referral to RNP (broken into felony / misdemeanor), to be added to Case Management tab in RNP Data Collection tool
- Access to and engagement with culturally appropriate, non-punitive, community-based resources

### System response

- Capacity and variety of local services aligned with RNP's commitment to harm reduction and holistic care
- Number and percent of substance-possession related law enforcement encounters (e.g., public order) that result in arrest, booking, and/or convictions for RNP-eligible behaviors, as well as the demographics of those individuals engaged by law enforcement in these encounters
- Racial disparity analysis that compares demographics of individuals who are arrested and booked into jail, compared to the demographics of those who are referred to RNP, among diversion-eligible individuals

### Quality of life

- Self-report quality life/well-being
- Improved mental and physical health
- ❖ **Services and Access Gap Analysis:** Indicated by comparing services needed/requested by RNP participants, referrals made, referred services received by BH-ASO region, and reasons why services were not received (if applicable). If the data collection burden for case managers is too great for this level of analysis, request that case managers report areas where service gaps are a persistent problem.
- ❖ **RNP Participant Satisfaction:** Collected via survey every six months following enrollment in RNP, with procedures in place outlining minimum and maximum contact efforts

### Concerns and Considerations

- A substantial investment is needed to secure the necessary software, staff to provide ongoing technical assistance, and staff to collect, analyze, and report the data.
- We don't have a list of the entities who are going to be collecting this information.
- The type of data these different organizations have, how they collect data, and specific types of data needed from each source must be clarified.
- This work needs long-term consistent funding for implementation, collection, and analysis.
- Need to be considering privacy of data; all data collected should be used for specified purposes and personally identifiable information should not be publicly available, especially to commercial data brokers.
- Need to confirm whether IRB approval is needed for this type of data collection and reporting.
- All data elements mentioned in this recommendation will need time frames specified (e.g., past 30 days? 90 days? Yearly rates?)
- Care needs to be taken around assigning causation to these data or using these types of measures as evaluation of efficacy of RNP or other system changes.
- Regarding the recommendation to include a measure of "Improved mental and physical health," a specific measurement tool still needs to be identified.
- Regarding the Services and Access Gap Analysis: This is a worthwhile area of inquiry, but it's operationally difficult. People may indicate desire for a service (public benefits, let's say), but the process of applying, getting denied (which is standard) and reapplying is time consuming and onerous - usually requires a case manager to help navigate, an SSI specialist, and ongoing effort. It's not just a matter of a referral and an outcome.
- For data related to RNP service referrals, "referred" has no operationally consistent definition: Is it somebody sent an email? Is the provider well-matched and culturally competent? Does the service provider have capacity, respond to the request, know how to reach the individual (who's usually hard to find)? Does the service provider think that completing the referral (getting the person connected) is their job, the client's job, or someone else's job? Does the referral remain active, meaning somebody keeps working to make it happen? Does the referring agency track and follow up to ensure the referred agency responds?
- The scope of data collection could be expanded to include other legislated diversion and jail alternative programs (in addition to RNP)
- Methods to share data must be developed and scaled, including utilization of a common data set, along with a common data model that automatically matches data fields across entities.
- This proposal doesn't include other data sources that may be of interest, such as mobile crisis response teams, the 988 line, and other crisis-level engagement programs.

### Collaboration with Existing Resources:

- ❖ **Existing state services/programs:** *This recommendation would involve both integration of existing data streams across agencies, and support for implementing consistent data collection platforms for recovery navigator programs as needed (where existing LEAD/AJA programs cannot be leveraged)*
- ❖ **Interagency involvement:** *This recommendation would require cooperation between all law enforcement agencies within the state, in addition to HCA, WASPC, local RNPs, local prosecutors, AOC, and tribal courts.*

- ❖ **Community partners:** *This recommendation would require collaboration with existing community-based service providers who are operating as the case management agencies for RNPs, and other pre-arrest diversion programs.*
- ❖ **Related grants or other potential funding sources:** *This recommendation would be most effective if implemented in partnership with existing HCA, WASPC, and other locally- and federally funded initiatives aligned with the collective impact goals and intentions of the RNP*

**Approximate Financial Support and Staffing Needed:**

Implementation would require additional funding to support the following:

- Staff and technical experts sufficient to develop and lead data strategy, handle data integration, and manage data interoperability while maintaining privacy and security.
- Staff to provide technical assistance for data collection and management to RNP sites and BH-ASOs
- Staff and/or outside technical experts to analyze and report.

**SURSA committee feedback**

No feedback on this recommendation was provided from SURSAC members during the pre-meeting review period







## Appendix O – Recommendation 14: Safe supply workgroup

**Recommendation** – Assemble a statewide workgroup to make recommendations on a framework for safe supply for inclusion in the Washington State Substance Use Recovery Services Plan to provide a regulated, tested supply of controlled substances to individuals at risk of drug overdoses. The workgroup should center people who use drugs, with lived and living experience, and who have lost loved ones.

This workgroup should consider values of (1) non-commercialization, and (2) alternative lawful income source for people who have been trapped in the illicit distribution economy and could be displaced by a safe supply program, to prevent potential unintended consequences that would disadvantage communities most impacted.

**Bill Requirement(s)** – Per 5476, this recommendation considers:

- Points of intersection that persons with substance use disorder have with the health care system and locations in which persons with untreated substance use disorder congregate (§1.3.a)
- Barriers to accessing the existing behavioral health system and recovery support services for persons with untreated substance use disorder, and possible innovations that could improve the quality and accessibility of care for those populations (§1.3.d)
- Evidence-based, research-based, and promising treatment and recovery services appropriate for target populations, including persons with co-occurring substance use disorders and mental health conditions (§1.3.e)

### Background and Supporting Data

The SURSAC has expressed broad support to establish a system to provide safe supply services in Washington State. With the understanding that there are several models to explore and many important implications and logistics to consider within those models, a special workgroup should be formed to decide on the details for a model that fits the needs and concerns of Washington residents who will be directly impacted by the implementation of a statewide Safe Supply system, including people who use drugs.

On September 12<sup>th</sup>, 2022, the SURSAC voted to recommend decriminalization of possession of controlled substances in Washington State. To realize the greatest public health, safety, and social benefit of this recommendation, people will need to be able to access their substance(s) of choice in a form that is as safe as possible to consume (safe supply) and to do so without interference (decriminalization). The resulting system reduces harm associated with drug use, including overdose and incarceration.<sup>33</sup>

Safe supply is defined as “A legal and regulated supply of mind or body altering substances that traditionally have only been accessible through illicit markets.”<sup>34</sup> Research has shown that:

- Safe supply has been shown to greatly reduce the chance of overdose for those who receive it.<sup>35</sup>

<sup>33</sup> [Addressing the Syndemic of HIV, Hepatitis C, Overdose, and COVID-19 among people who use drugs: The potential roles for decriminalization and safe supply \(2020\)](#)

<sup>34</sup> [Safe Supply — CAPUD](#)

<sup>35</sup> [Evaluation of an emergency safe supply drugs and managed alcohol program in COVID-19 isolation hotel shelters for people experiencing homelessness \(2022\)](#)



- Safe supply reduces riskier use and promotes safer use over time.<sup>36</sup>
- Safe supply in certain models reduces theft, petty crime, and syringe litter. It also returns autonomy and time to people’s day, and increases prosocial engagement with their communities.<sup>37,38</sup>

The following qualitative studies also demonstrate the value of these programs to their communities:

[“People need them or else they’re going to take fentanyl and die”: A qualitative study examining the ‘problem’ of prescription opioid diversion during an overdose epidemic \(2021\)](#)

[“It’s helped me a lot, just like to stay alive”: A qualitative analysis of outcomes of a novel hydromorphone tablet distribution program in Vancouver, Canada \(2021\)](#)

[Implementation of Safe Supply Alternatives During Intersecting COVID-19 and Overdose Health Emergencies in British Columbia, Canada, 2021 \(2022\)](#)

Below are four potential models for the workgroup to consider, as presented by Adam Palayew during the SURSAC Special Meeting on September 9<sup>th</sup>, 2022:

**Table 1.** Characteristics of different safe supply frameworks under consideration.

Scenario	Framework 1: Prescription (supervised consumption)	Framework 2: Prescription (unsupervised consumption)	Framework 3: Buyer’s Club	Framework 4: Dispensary (not for profit/for profit)
Description	Drugs are prescribed and administered in a supervised setting under the care of health professionals and/or peer workers.	Drugs are prescribed and dispensed by a health care provider at a dedicated facility, but PWUD have the option to administer it on their own terms outside of a supervised setting, such as their own	Buyers Club: Network of people in community. Pool money and buy from a source and then use that to purchase drugs in bulk, test them, package them and provide them back to the community. Buyers come together and collective purchasing. (e.g.	Drugs can be made available without prescription in dispensaries and shops (e.g., cannabis). This model can be run in a for profit or a non-for profit manner. There can also be restrictions who can access these locations including based on age.

<sup>36</sup> [Characterizing safer supply prescribing of immediate release hydromorphone for individuals with opioid use disorder across Ontario, Canada \(2022\)](#)

<sup>37</sup> [Safer supply pilot project findings - Canada.ca](#)

<sup>38</sup> [Vancouver’s Unconventional Approach to Its Fentanyl Crisis - The New York Times \(nytimes.com\)](#)

		home, in take home doses.	Dallas Buyers Club; History of HIV Meds). Grassroots, no physical location. Less institutional	
<b>Delivery</b>	Prescriber	Prescriber	Alternative	Alternative
<b>Population coverage</b>	PWUD in contact with health system	PWUD in contact with health system	All PWUD	All PWUD

Some safe supply features can be implemented in any of these frameworks<sup>39</sup>:

1. Licenses for purchasing, coupled with education
2. Signing of waivers acknowledging risk
3. Putting labelling on packaging about health messages and where to seek help if desired
4. Education related to use and accompanying harm reduction supplies

Concerns and Considerations

*Some questions and concerns that arose following the Safe Supply 101 presentation on September 9<sup>th</sup> ([starts at 00:55:30 in the meeting recording](#)) are outlined below, with responses from Adam Palayew (University of Washington).*

***Q: (Part 1) You can look at the reduction in death among people who participate in the program. But how about people out in the community? So that's the first question.***

A: There is ongoing work to try and find the answers to those questions. It's very hard to evaluate because then you need to go and find people who got these diverted medications, which isn't always easy. There is some qualitative research around it, nothing quantitative, but the qualitative research is focused on some people getting diverted medications, and it was safer for them. Some people call it diversion, a reframing of it would be secondary safe supply or secondary treatment.

However, there is a real concern that people could be getting these medications, and then new people using them. But I think the alternative is that they [new users] would just be accessing the street supply instead of these medical grade medications or drugs. The issue becomes that someone who's accessing the illegal supply is at a much higher chance of overdosing and dying and not knowing what they're putting in their body versus one of these diverted medications. I

<sup>39</sup> [A public health based vision for the management and regulation of opioids \(2021\)](#)

think diversion is a real issue. It's hard to quantify. I think there's both benefits and negative consequences to it.

In some of the ongoing modeling work, there are threshold analyses being built in around diversion that address what happens if 50% of drug use increases based off these models, what happens if 100% increase? What happens if there's a 150% increase in people accessing these drugs? You can change the amount of people that will increase and see at what point where your model would say that more overdose deaths are happening because we're implementing this, and so you can get out a number for what percent increase would need to happen for diversion to be an issue at a population level.

Similar concerns have been raised about methadone and past analyses have looked at mortality and poisoning data, particularly for children. Such poisoning events are extremely rare, and OTP's require patients to store take home medications in a lock box.

***Q: (Part 2) And the second question is the question about scale. I can see this being extremely helpful for people, but at least my knowledge of the programs in Vancouver, in Zurich, is it's only a small number of people. And given how big this current epidemic is we're in, I think it's important to do everything we can, but it's also important to be realistic about how many people were going to affect.***

A: I think scale is an important issue. Safe supply has been tremendously successful for those who've accessed it. However, as they've tried to scale it up, there's tons of barriers. Some physicians have not been willing to prescribe it. They say it goes against their Hippocratic Oath. There are pharmacists who refuse to fill prescriptions. It's hard for people to access it. It's also only really been implemented for people with a substance use disorder, which is a limited segment of the population that is at risk of overdose. Thinking boldly about models that are widely accessible to people in terms of regulation like cannabis and alcohol is how you're going to have the most scale and impact.

However, that also comes with more extreme options that we have for a safe supply. And I think the prescriber based safe supplies can be thought of a lot as a continuation of treatment as we've talked about before, where if you're giving someone heroin three times a day or twice a day, similar to how they're dispensing methadone. You need to dispense heroin more because it's a shorter half-life, but you basically have just another option for treatment for people to choose from.

***Q: You had mentioned the prescribe and take-home method and then I think you alluded to some of the difficulties with that, having doctors willing to prescribe and pharmacists. Are there places where that is successful right now? The reason why I ask is, just looking at my community, I can't imagine a location where a clinic could go in where there wouldn't be total outrage by the neighborhood. I'm intrigued by the prescribed and take home and so are there places where that is being tried?***

A: Yes, it has been tried in several places, and it's been very successful. Vancouver is one of them as well as many places in Canada including Quebec, Ontario, and Nova Scotia. I presented some of those results. There's also published data from Switzerland where they found that both by

relaxing the take home requirement instead of having people come to the clinic every day, they both increase the number of people they were able to expand it to, because it allowed more people to accommodate it in their lives, as well they didn't have any increase in negative outcomes with the program. It's being done successfully. There are multiple places in Canada and those references and evidence are in the slides.

On the other hand, you're talking about the political reality of this, and would it be acceptable and all of that? And I would say you can't know until you try. I completely agree that there will be a ton of political backlash if one of these are implemented. I think we could all see the headlines already of what would happen. Someone made a comment in the chat about, dare I ask, who's paying for this? And I would say that implementing safe supply, I think is going to end up being cost saving because you're reducing the burden on the medical system by a large amount.

A lot of this evidence now is going to be coming out looking at cost effectiveness or cost savings with these programs that have been operating for over a year now in other countries, and what were the economic impact of them.

It's a tough sell. There will be political opposition. But people's lives are at stake. I think this is something that's been shown to be successful, that has a lot of evidence behind it. And I think we should be doing and thinking, doing bold action, and thinking boldly about how to keep our community safest.

Cost analyses would need to look at total societal costs, not just health care system costs to see the total impact of such a program.

***Q: Where do supply testing options fit into any of these models like options for testing street supply?***

A: Testing for the street supply is important because people would still be using the street supply in some of these models. But drug testing is a reaction to the fractured street supply and how dangerous it is; we don't go test our alcohol, we don't test our cannabis, we don't test our coffee for dosage and purity. In an ideal world where safe supply is properly implemented, drug testing could take a back seat, which again goes to reinvesting resources that are allocated for different interventions to things that could replace it.

***Q: Is there a reduction in crime, in burglaries, and law enforcement issues in those areas where a safe supply was created? Is one of the metrics the number of individuals who have been diagnosed, and those who have become addicted to those drugs? Because a safe supply is great for those who are already in that world, and who are already addicted. But if the safe supply is promoted, and all it does is create more addicts, then I'm not sure that is quite the direction we want to go. But I do like the idea for addressing the people who already have that addiction.***

A: In terms of the reductions in crime, I would say there hasn't been any spatial analysis where they look at the neighborhood level and these programs. However, in the data that I was referring to, they directly asked the participants –did you commit, more crime, less crime, did you commit any crime as well to get your drugs – and asking how their behavior individually changed, but there hasn't been any neighborhood level studies that have been done around crime and

burglary and law enforcement, for safe supply yet. There's only the individual level data as of now. It's always hard to look at the neighborhood level data to then extrapolate to the individual level. There's so much going on that influences what's happening at that macro scale. [There are research approaches to investigating neighborhood crime associated with different types of venues such as bars, OTP's, and convenience stores

<https://www.jsad.com/doi/10.15288/jsad.2016.77.17> ]

And in terms of safe supply for those who don't use, I agree that you need to think about the alternative. I know it could be a little uneasy that people who don't use drugs could be accessing these drugs, but if we think about our 20-year-old linebacker who died, in the prime of his life in college, he used the street supply trying to access Xanax where he didn't know what he was getting, and that's truly the alternative to a safe supply: our current status quo where people are accessing illegal supply that is from a very fractured supply, that has a ton of contaminants.

It may be uncomfortable, but are we OK with letting people use drugs die knowing that they're going to use drugs? We need to give them a safe alternative, like what we've done with alcohol. Rep Davis made a really good point about the commercialization of alcohol, which I think is a really important point; we need to think about how you legalize these in terms of restrictions on advertisement restrictions on making profits, because when these were more widely available in the early 2000s, there was a lot of deceit in advertisement that was going on, and it was really dangerous and really damaging to the public health. And so I think we need to be very careful in how we legalize this and offer a safe supply, thinking about designing these systems to better the public health, instead of making it into a type of capitalistic feeding frenzy. [Concerns were raised at the meeting and have been raised publicly that the cannabis market in Washington State has been very poorly regulated, with profit driving perverse incentives e.g. high potency products and that we would definitely want to avoid the negative impacts of the market structure currently seen with cannabis in WA.]

*Comment: Let's remember that's we've had safe supply for 70 years, and that is in the form of other treatment medications. So safe supply isn't really safe supply, it is medications, right? Methadone is a full opiate agonist. All we're talking about is other types of full opiate agonist. Research in Canada has examined the use of hydromorphone (e.g. Dilaudid) and diacetylmorphine (aka heroin) <https://pubmed.ncbi.nlm.nih.gov/27049826/>. We're just trying to fight a fight of a brand new super synthetic high potency drug with tools that are 70 years old and all that we're talking about is bringing their tools and other medications into the mix. The reason why we're in this problem of fentanyl and especially in counterfeit pills, is because we did so much to tamp down on prescribing practices that we took a fully regulated supply on, and we got rid of it. We created this inadvertent marketplace for a really contaminated drugs in public health. One of the questions I get all the time is do we have fentanyl in marijuana and that is such an easy question to answer here in the state of the Washington. And the answer is no. Almost across the board, No. And the reason is because we have end to end quality control on that; when we don't have end to end quality control, we create this marketplace for this toxic drug.*

**Collaboration with Existing Resources:** *To implement safe supply services, collaboration will be needed with:*

- ❖ *Doctors and other prescribing medical providers*

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- ❖ *Pharmacies and pharmacists*
- ❖ *Insurance providers*

**Approximate Financial Support and Staffing Needed:** *To be determined by workgroup*

Dollars	FY23	FY24	FY25
Legislative / State Budget Funding			
HCA Grant-Based Funding			
Total Funds			
Staff (FTE)	0	0	0

### SURSA Committee feedback

No feedback on this recommendation was provided from SURSAC members during the pre-meeting review period



Appendix P – Recommendation 15: Expanding funding for OTPs to include partnerships with rural areas

**Recommendation** – Increase access to opioid treatment program (OTP) services in rural areas

**Definitions to know for recommendations**

**Opioid treatment program-** An opioid treatment program (OTP) is a behavioral health treatment agency which is licensed by the state and federal government, and in accordance with RCW 71.24.590 and 42 CFR § 8.11. OTPs offers both counseling services and medical services to all clients who attend. It is the only type of outpatient treatment setting, where an individual can receive all three types of medication for the treatment of an Opioid Use Disorder: Methadone, Buprenorphine products (Suboxone, Subutex), and Naltrexone (Vivitrol). A client who attends an OTP receives their MOUS medication and doses to take home directly from the OTP site, instead of a pharmacy. There are no prescriptions.

To provide this array of services, OTPs have multidisciplinary treatment teams that include: Prescribing practitioners (i.e., medical doctors, doctors of osteopathy, advanced registered nurse practitioners, physician assistants); Nurses (i.e., licensed practical nurses and registered nurses); and Counselors (SUD professionals)

- [Opioid treatment program guide \(wa.gov\)](#)

**OTP Medication Unit-** According to 42 CFR § 8.11(i)(1), a certified OTP may establish a medication unit or units to administer or dispense medication therapy. The state and federal licensed OTP assumes all responsibilities for any medication units associated with it. Such a unit is intended to facilitate access to medication-assisted treatment for patients who would otherwise have to travel great distances. These medication units under federal law can be (1) located as a free-standing facility; (2) co-located within in a variety of community settings such as but not limited to hospitals/medical primary care systems/pharmacies/FQHCs etc.; and (3) located as a mobile medication vehicle.

Detailed recommendations for consideration:

1. **Require the Dept. of Health’s Health Services Quality Assurance (HSQA) division create a regulatory workshop with OTP provider stakeholders in 2023 to:**

**Create state rules/regulatory process for OTP that want to establish offsite medication units (1) located as a free-standing facility; (2) co-located within in a variety of community settings such as but not limited to hospitals/medical primary care systems/pharmacies/FQHCs, as well as correctional health settings, etc.**

- DOH already has set up a regulatory process for OTP to apply for mobile medication units specifically, but not other types of medication units.
- DOH should set up a process for regulating and establishing all types of OTP medication units allowable under federal law.
- Ensure DOH includes invited stakeholders from geographic regions areas of WA with lower population density, Eastern Washington, rural, tribal nations, etc. This way DOH can ensure decision making is done in a more equitable manner that is inclusive of



important stakeholder partners who may be impacted by changes proposed to help their communities.

**Goal:** To increase number of OTP and methadone access in Central and Eastern WA and/or rural areas

**Requires:** Regulatory changes, and directive to State Agency- Dept. of Health

2. **Change RCW [36.70A.200](#) and WAC [365-196-550](#) to ensure that OTP branch sites of all kinds (including mobile, and fixed, site medication units) are clearly seen as “essential public facilities” and that they cannot be zoned out or stalled by moratoriums by City and/or County legislative authorities.**

- RCW 71.35.590(b) references that OTP are to be seen as an essential public facility
- However, RCW 36.70A.200 and WAC 365-196-550, which are written to define “essential public facilities” are written in a way that many City and County legislative Authorities, and their respective planning commissions have reported as being less than optimal in clarity, if opioid treatment programs are included.
- Updating RCW 36.70A.200 and WAC 365-196-550 to be explicit that opioid treatment programs are clearly defined as a “essential public facility” type would help city and county legislative authorities in their confusion, and hopefully help to assert that our continuum of care values this provider setting as “essential” bringing dignity and equity to patients, declaring this is the same setting type as other healthcare setting types.
- Washington State Opioid Treatment Authority has had to interact with many City and County Legislative Authorities and their respective planning commissions on this topic, and often local municipalities want to create zoning requirements for OTP that are different and more burdensome than other behavioral health and/or physical health setting types.
  - For example, many local municipalities have set up burdensome moratoriums before decision making and/or stigmatizing public comment periods specifically for prospective OTP providers, before allowing zoning feedback for opioid treatment programs that should be treated the same as other healthcare facilities.
  - Recently 4 King County Cities would not allow a prospective OTP mobile medication unit to bring services to their cities, and several of the cities talked with the OTP about the need to set up moratoriums while they wait to decide if the OTP mobile medication unit should be zoned as a “food truck” and/or threatened to not allow them a permit to operate in a mobile capacity within city limits saying they needed to be zones as a “permanent” structure.
- Clearer state laws and rules on this topic would help local municipalities to make decisions with their respective planning commissions and help to bring much needed MOUD/methadone treatment to communities that previously have not had access to MOUD/methadone.

**Goal:** To increase number of OTP in Central and Eastern WA and/or rural areas, bring more alignment with state and federal civil rights laws like ADA and WLAD, and bring more equity and dignity and respect for patients

**Requires:** Regulatory Changes, and changes to RCW and WAC

3. Update RCW 71.24.590 to remove several requirements for the siting of opioid treatment programs that stigmatize the treatment setting type and treat it in ways that other SUD behavioral health agencies and health care facilities settings are not.

This would include removing the largely symbolic RCW requirement in RCW 71.24.590(2) that allows a county legislative authority to cap the patient census of an OTP specific setting, at no less the 350 individuals.

This would include removing all OTP public hearing requirements in this RCW, that describe how DOH must facilitate a public hearing in the community which an OTP will be cited in, before a new OTP can open to operate.

Consideration for resources to help create opportunities for public engagement that center patients and prospective patients at educational opportunities for the general public. Include a community engagement process that seeks to reduce stigma around those with substance use and has a primary goal to center and protect patients through education related to sharing evidence-based treatment outcomes related to OTP.

- Recommend removing all “patient census cap” language in this RCW. Instead, specifically state that “no city or county legislative authority can create a patient census cap” at an OTP.
- Possibly tie a reference into any changes to RCW, related to the previous recommendation that an OTP be noted clearly as a “essential public facility” and assert clearly that they need to be treated like any other essential public healthcare facility and be privy to the same reasonable conditional use requirements as other health care settings.
- Remove all OTP public hearing requirements in this RCW, as DOH is legally required to license any qualified treatment setting provider and causing OTP to need to go through public hearings is not a good use of taxpayer dollars, adds time and burden to providers who seek to become licensed by Washington State to open an OTP and allows for further stigmatization against this setting type in the communities where they operate.
- No other behavioral health agency setting type, or medical setting type needs to undergo an RCW mandated public hearing facilitated by WA DOH HSQA staff. Why are OTP being treated differently than any other SUD Behavioral Health Agency (BHA) provider type? It is stemming from a history of stigma and “othering” that needs to end.
- The siting of OTP treatment settings should be treated in a manner similar to the siting of other behavioral health agencies, and health care facilities in Washington State.

**Goal:** To increase number of OTP in Central and Eastern WA and/or rural areas, bring more alignment with state and federal civil rights laws like Americans with Disabilities ACT (ADA) and Washington Law Against Discrimination (WLAD), and bring more equity and dignity and respect for patients

**Requires:** Regulatory Changes to RCW 71.35.590

**4. Funding for capital construction costs to help start up OTP in Central and Eastern- WA**

A model of funding already exists where Dept. of Commerce has been given funds by the WA Legislature to help with capital construction costs to build recovery housing/transitional housing stock- Perhaps a similar model should be offered to help cover capital construction costs to build new OTP.

- The service delivery and treatment services of an OTP are already insurance reimbursable, so the request for funding would go to helping with capital construction, startup costs only to help bring an OTP to specific regions of the state that currently lack OTP/methadone access.
- Recommendation could easily be scaled upward and downward and implemented in a targeted region(s).
- Please see high level estimated budget costs below.
- More detailed cost estimates could be available from HCA staff upon request in the event the Legislature seeks to fund this.
- Could also be recommended as a use of opioid settlement funds, GSF etc.
- There should be support for provider evaluation of outcomes

**Goal:** To increase number of OTP in Central and Eastern WA and/or rural areas, bringing treatment to new populations who have previously not had access to MOUD/methadone.

**Requires:** Resources and funding and legislative directives with State Agency- Dept. of Commerce.

**5. The Governor’s Office and/or Legislature should provide funding to a State Agency such as WA Health Care Authority to provide an RFI/RFP to resource established OTP in Washington State to operate an increased number of OTP medication units to expand their geographic reach**

These medication units could be established in a variety of forms. (1) Located as a free-standing facility; (2) co-located within in a variety of community settings such as but not limited to hospitals/medical primary care systems/pharmacies/FQHCs etc.; and (3) located as mobile medication vehicles.

This could be done to extend the geographic reach of OTP and bring medications for opioid use disorder, counseling, and other recovery support/SUD treatment services to greater geographic areas and to literally meet novel patient patients where they are at.

- WA Legislature funded 5 OTP mobile medication units in the State of WA. Implementation is in the works at the present time.
- Recommendation could easily be scaled upward and downward and implemented in a targeted region(s).
- Please see high level estimated budget costs below.
- More detailed cost estimates could be available from HCA FSD staff upon request in the event the Legislature seeks to fund this.
- Also, could be recommended as a use of opioid settlement funds, SABG, SOR and GSF funds.
- There should be support for provider evaluation of outcomes

**Goal:** To increase number of OTP and methadone access in Central and Eastern WA and/or rural areas, bring treatment to new populations who previously have not had access to MOUD/methadone.

**Requires:** Resources and funding, and legislative directives.

#### Bill Requirement(s)

This recommendation establishes new community-based care access points (1.3.b), expands regional capacity for treatment via opioid treatment programs (1.3.c), and removes geographic barriers to accessing OTPs (1.3.d).

#### Background and Supporting Data

Washington State is experiencing a fentanyl-driven overdose crisis. Current trends shown on the Washington State Department of Health (DOH) Opioid Overdose website suggest the total number of overdoses will be the highest recorded. Fortunately, there are effective medications for the treatment of OUD.

While two of the three Food and Drug Administration (FDA)-approved medications can be prescribed in a primary care office, OTP behavioral health agencies are the only outpatient treatment setting where federal law permits the use of all FDA-approved medications for the treatment of OUD: methadone-, buprenorphine-, and naltrexone-containing products.

Methadone is described as a “full agonist”, meaning it completely binds to and fully activates opioid receptors in the body. It is the most potent FDA-approved medication allowed for the treatment of OUD. It can only be dispensed for the treatment of OUD in an outpatient OTP or “methadone clinic”.

Buprenorphine, which can be prescribed outside of OTPs, also occupies the opioid receptor, but it is not as potent as methadone. This is an important distinction to highlight. Buprenorphine was developed to treat OUD, when heroin and prescription opioids were the primary substances being used by people with OUD. Because fentanyl is a much more potent opioid than heroin or oxycodone, many people using fentanyl require methadone medication to treat their OUD, increasing the need for services provided in OTPs.

As of September 1, 2022, there are 32 OTPs in Washington State, each serving between 200 to more than 1,000 patients. There is no federal rule limiting the number of individuals an OTP can serve, but state law

in RCW 71.24.590(2) does allow counties to set patient census limits (i.e., maximum capacity for a program).

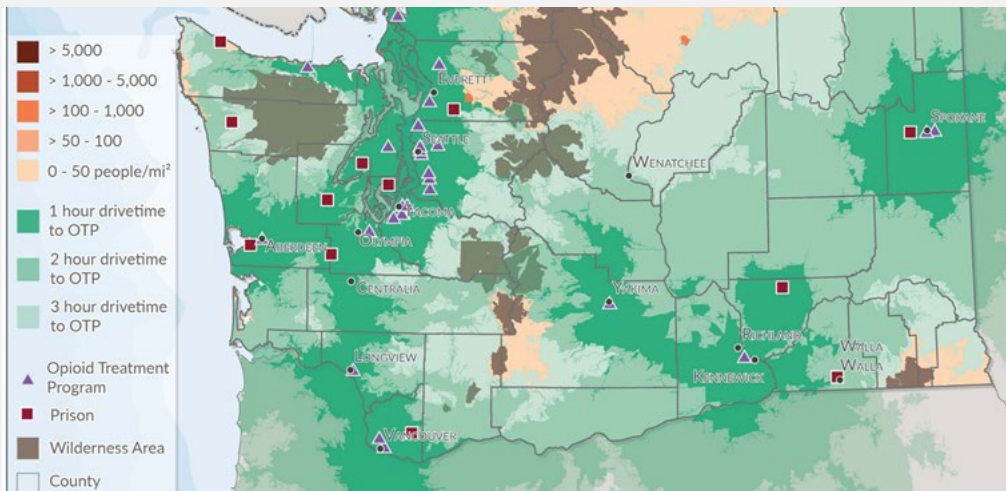
5 of the 32 OTPs are owned and operated by Washington State Tribes (i.e., Lummi, Muckleshoot, Stillaguamish, Swinomish, Jamestown S’Klallam).

OTPs in Washington State collectively serve more than 14,000 people with a primary OUD diagnosis. Using information from the HCA Opioid Use Disorder Treatment for Medicaid Population dashboard, 15% of people with Medicaid being treated for OUD are receiving care in OTPs.

Access to methadone is not equal across the state. Few programs exist in central and eastern Washington.

Below is a map created for HCA by the Pew Charitable Trust representing areas of Washington State with significant gaps in the treatment continuum for patients looking or methadone medication access in opioid treatment programs.

As you can see, most of Central, Eastern and/or rural Washington is 2, 3, or 3+ hours drive time away from an OTP and thus methadone medication for the treatment of OUD.



Given the increased potency of fentanyl, the need to use methadone as the most potent opioid replacement therapy is expected to increase. As OTPs are the only agencies allowed by federal law to treat people experiencing OUD with methadone, this report has become more relevant. The need to provide standardized, high-quality care in OTPs that meets federal and state requirements has never been more important.

Concerns and Considerations

There was zero dissension of any kind from any of the SURSAC Treatment subcommittee members, when these recommendations were offered in the SURSAC Treatment Subcommittees on August 23, 2022, and September 6, 2022.

**Additional Feedback from SURSAC Treatment subcommittee members included:**

- If work happens with DOH for OTP rulemaking- To please ensure DOH includes invited stakeholders from geographic regions areas of WA with lower population density, Eastern Washington, rural, tribal nations, etc. This way DOH can ensure decision making is done in a more equitable manner that is inclusive of important stakeholder partners who may be impacted by changes proposed to help their communities.
- Request that one of the SURSAC subcommittees should take up a future a recommendation to find a way to include syringe service programs as a facility setting type that would benefit from protection under RCW as a “essential public facility”
- Request that one of the SURSAC subcommittees should take up in the future a recommendation MOUD in jails specific setting recommendation to support increased methadone access in jail settings.
- Request that one of the SURSAC subcommittees should take up in the future a recommendation to address more thoroughly and holistically whole person health needs (physical, mental health, SUD) of individuals in any setting of incarceration (Jails and Prison and JRA settings)

**Collaboration with Existing Resources:** *How can this recommendation collaborate with existing services / programs / resources?*

❖ **Existing state services/programs:**

- Opioid treatment programs are already a behavioral health agency setting type that exists, are clearly defined in state and federal law, and offer both medical and counseling services to patients making them fully in alignment with the state’s goals of offering integrated care settings to Washingtonians.
- Opioid treatment programs are existing and insurance reimbursable integrated behavioral health services under Medicaid, Medicare, and all other third-party insurance payers.
- There are already 32 opioid treatment programs in Washington State as of 9/20/22.
- [Opioid treatment program guide \(wa.gov\)](#)

❖ **Interagency involvement:**

- These recommendations involve changes that would require work from the Washington State legislature, Washington State Dept. of Health, Washington State Health Care Authority, Washington State Dept. of Commerce, and Washington State DOC to implement. Partners are dependence on the respective recommendations.

❖ **Community partners:**

- Licensed behavioral health agencies that are opioid treatment programs
- Other entities that can refer to opioid treatment programs, including primary care providers, hospitals, emergency departments, FQHCA, rural health clinics, behavioral health agencies, office based opioid treatment settings, syringe service programs, Hep C/HIV providers, settings that help drug user health locations, etc.
- There are also currently 5 tribally owned and operated OTPs in Washington State, the most in the nation, serving both tribal member and non-tribal affiliated patients in their communities.

## SUBSTANCE USE AND RECOVERY SERVICES PLAN

❖ **Related grants or other potential funding sources:**

- Many of the recommendations are regulatory in nature and do not require funding
- The recommendations where is funding required could be funded through GSF, opioid settlement funds, and one specific recommendation could also potentially be assisted with use of SABG funds and SOR funds.

**Approximate Financial Support and Staffing Needed:**

**For the OTP Capital construction Costs with Dept. of Commerce recommendation:**

As per opioid treatment program Providers:

- As per initial provider feedback: \$600,000 up to \$1.2 million per OTP to remodel an existing structure and turn into an OTP that could be leased to a provider
- As per initial provider feedback: \$1.2 million up to \$2.4 million to build from scratch an OTP that would be owned and operated by an OTP provider.
- Dept. of Commerce would need an TBD FTE to help implement
- Dept. of Commerce Financial staff would need to do modeling of whatever final amounts would be requested; variables will differ based on a large number of TBD factors.

**For the increasing OTP medication unit proposal with WA Health Care Authority recommendation:**

- WA Legislature provided HCA with funds in 2022 to bring up to 5 OTP mobile medication units in the State of WA.
- Costs covered capital, start up and staffing costs in an ongoing manner. Implementation is in the works at the present time.

Below is a summary by year of amounts budgeted for the 5 mobile OTP project. They are rounded to nearest 1000.

Item Title	General Fund - State	General Fund - Medicaid Federal	Grand Total	General Fund - State	General Fund - Medicaid Federal	Grand Total	General Fund - State	General Fund - Medicaid Federal	Grand Total
	SFY 2023			SFY 2024			SFY 2025		
<b>Mobile Opioid Treatment Services Totals</b>	\$2,825,000	\$797,000	\$3,622,000	\$2,336,000	\$1,518,000	\$3,854,000	\$2,336,000	\$1,518,000	\$3,854,000
Admin	\$71,000	\$71,000	\$142,000	\$66,500	\$66,500	\$133,000	\$66,500	\$66,500	\$133,000
Direct provider contracts	\$1,135,000	\$726,000	\$1,861,000	\$2,269,500	\$1,451,500	\$3,721,000	\$2,269,500	\$1,451,500	\$3,721,000
BH-ASO			\$0			\$0			\$0
Start UP	\$1,619,000		\$1,619,000			\$0			\$0
<b>Amount to Include (Calculated)</b>	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0

**SURSA Committee feedback**

No feedback on this recommendation was provided from SURSAC members during the pre-meeting review period









Appendix Q – Recommendation 16: Addressing zoning issues regarding behavioral health services

**Recommendation** – *Addressing outdated language regarding recovery houses licensing and zoning barriers affecting treatment, harm reduction, and recovery support services.*

**Bill Requirement(s)** – *5476 Section 1.3 (a),(c),(d),(j)*

**Background and Supporting Data:**

This recommendation addresses outdated language regarding recovery residence licensing and zoning barriers affecting treatment, harm reduction, and recovery services, as well as the inconsistency between state, county, and city/town regulations regarding zoning for these types of facilities.

A blanket statement from the state level would provide considerable changes to these areas in regard to providing adequate space for treatment, harm reduction, and recovery support services.

Currently, [WAC 365-196-550](#) outlines essential public facilities when it comes to community development regulations. Siting these essentially public facilities are outlined in [RCW 36.70A.200](#) which states that county and city planning includes a process for identify and siting the facilities that are named under the WAC and RCW which includes inpatient facilities including substance ‘abuse’ facilities, mental health facilities, group homes, and community facilities. It is left to the discretion of the city and county to identify and site these locations within their areas.

Oftentimes, this provides city and counties to not provide adequate services due to the lack of appropriate identification and appropriate language of the services that are needed to address the substance use, mental health, and co-occurring population.

The language should be updated to include in-patient, out-patient, recovery residences, harm reduction (including SSP), community-based, and treatment related programs, including OTPs and mobile treatment services. Furthermore, there should be consistency, regardless of demographic, for enforcing cities and counties to provide the maximum amount of services within their regions.

Recovery Residences should be defined as: Recovery housing can range along a continuum of four non-linear levels described by the National Association of Recovery Residences (NARR). These levels range from peer-run establishments like Oxford Housing (level I), to monitored sober living homes (level II), to supervised housing (level III), and residential treatment housing (level IV). While recovery residences vary widely in structure, all are centered on peer support and a connection to services that promote long-term recovery.

*Recovery housing benefits individuals in recovery by reinforcing a substance-free lifestyle and providing direct connections to other peers in recovery, mutual support groups and recovery support services. Substance-free does not prohibit prescribed medications taken as directed by a licensed prescriber, such as pharmacotherapies specifically approved by the Food and Drug Administration (FDA) for treatment of opioid use disorder as well as other medications with FDA-approved indications for the treatment of co-occurring disorder.*

## SUBSTANCE USE AND RECOVERY SERVICES PLAN

To further this recommendation in efforts to support harm reduction services in Washington, the subcommittee recommends adopting similar language to [California Health and Safety Code 11364](#) which states *“a public health measure intended to prevent the transmission of HIV, viral hepatitis, and other bloodborne diseases among persons who use syringes and hypodermic needles, and to prevent subsequent infection of sexual partners, newborn children, or other persons, this section shall not apply to the possession solely for personal use of hypodermic needles or syringes.”* Allows for providing supplies to reduce harm associated with SUD, which includes safe smoking supplies.

To help facilitate the changes to zoning regulations, we believe municipal officials would benefit from orientation to the services we are recommending be sited in their jurisdictions. When given adequate information and statistical data, officials would be better able to make informed changes for their communities to address the current substance use crisis. Educational campaigns should be provided to city and county officials and communities to provide valuable information regarding the services that may be sited in their areas. Stigma and misunderstanding can cause resistance that could hinder the expansion of vital services.

**Collaboration with Existing Resources:**

N/A

**Approximate Financial Support and Staffing Needed:**

Dollars	FY23	FY24	FY25
Legislative / State Budget Funding			
HCA Grant-Based Funding			
Total Funds			
Staff (FTE)	8	6	6

**SURSA Committee feedback**

No feedback on this recommendation was provided from SURSAC members during the pre-meeting review period





## Appendix R – Recommendation 18: Continuum of Housing

**Recommendation** – The SURSAC urges the state to provide capital budget and operating funding for options for housing at the various points of intersection along the continuum of care for housing people who are currently using to those who are in recovery, which may or may not include abstinence, from immediate shelter to bridge/transitional housing through long-term permanent housing. It is urgent that the Legislature fund a continuum of housing and housing services for individuals who use drugs and those who are abstinent. The resources need to include capital and operating investments.

Participation in, and collaboration with, work on these topics already being done is also encouraged, including but not limited to:

- Permanent Supportive Housing Advisory Committee, established per [HB 1724v](#)
- Behavioral Health Housing Action Plan
- Washington State Health Care Authority
- Washington State Department of Health
- Washington State Department of Commerce
- Low Income Housing Institute
- The Washington Alliance for Quality Recovery Residences
- Public Defender Association (PDA) CoLEAD/JustCARE
- Evergreen Treatment Services REACH Program
- Downtown Emergency Service Center
- Plymouth Housing
- Catholic Community Services

Participation and collaboration in this work should include bringing forth known models and systems for consideration, such as:

- Extending the Housing and Recovery through Peer Services program ([HARPS](#))
- Expanding longer-term rental resources
- Building on the work from the Permanent Supportive Housing (PSH) advisory group, Behavioral Health Housing Plan, AHAB housing needs assessment, and other ongoing efforts to address housing needs
- Replicating the JustCARE model of immediate placement in bridge housing and creating permanent housing placements via coordination with Coordinated Entry teams (now being employed by King County Regional Homelessness Authority to respond to individuals living on state transportation rights of way under contract with the Department of Commerce)
- Creation of state or local long term housing voucher programs for up to 100% of housing costs
- Leveraging existing sources of funding for housing
- Crisis stabilization housing for those waiting for a withdrawal management/detox or an inpatient treatment bed
  - Outreach programs that assist individuals in accessing treatment often use motel/hotel vouchers while someone is waiting for inpatient treatment; however, these funds are not always available

- Housing for those who have an active drug addiction and/or a mental health disorder
- Recovery-supportive housing for those who are in recovery or seeking recovery from substance use disorder
- [Master leasing](#) as a strategy to address the affordable housing crisis
- Government-subsidized housing for persons receiving Medications for Opioid Use Disorder (MOUD) as part of active treatment (e.g., Kate’s House model) Level 1 and Level 2 recovery residences.

[This is the registry of Level 1 and 2 recovery residences in Washington State.](#)

*Counties with no Level 1 or 2 residences listed are:* Jefferson, San Juan, Pacific, Lewis, Wahkiakum, Skamania, Klickitat, Ferry, Stevens, Pend Oreille, Lincoln, Adams, Whitman (no data available to confirm), Columbia, Garfield, Asotin

- Obtaining additional grant funding to expand current accredited and reputable operators to develop recovery residential options for the regions indicated above (counties with no level 1 or 2 residences, according to the online registry), and expand residential options into these areas for underserved and marginalized communities.
- Amending [RCW 59.18.030](#) as part of transitioning individuals from long-term or supportive housing into permanent housing, such as by adding the underlined language provided in the two following examples:

*(5) "Criminal history" means a report containing or summarizing (a) the prospective tenant's criminal convictions, not including criminal convictions related to Unlawful Possession of Controlled Substances under RCW 69.50.4013 and pending cases, the final disposition of which antedates the report by no more than seven years, and (b) the results of a sex offender registry and United States department of the treasury's office of foreign assets control search, all based on at least seven years of address history and alias information provided by the prospective tenant or available in the consumer credit report*

**OR**

*(5) "Criminal history" means a report containing or summarizing (a) the prospective tenant's criminal convictions, not including all drug-related convictions and pending cases, the final disposition of which antedates the report by no more than seven years, and (b) the results of a sex offender registry and United States department of the treasury's office of foreign assets control search, all based on at least seven years of address history and alias information provided by the prospective tenant or available in the consumer credit report.*

- Reducing financial barriers to securing permanent housing posed by the cost of housing applications, background checks, and move-in fees
- Models for connecting private property owners and managers with those who need affordable housing (e.g., Housing Connector)



- Expanding Housing First Model across Washington
  - Principles for Housing First temporary lodging or permanent housing investments:
    - **Non-congregate:** We learned during the pandemic that non-congregate lodging arrangements are in general calmer, more dignified, and more welcoming for many people with behavioral health conditions, than congregate shelter settings. Non-congregate bridge housing arrangements can include self-contained apartments, SRO-style accommodations, hotel-style accommodations, or tiny homes.
    - **24/7 availability:** Accommodations that require people to exit during the day foster instability, and force individuals into public areas, increasing vulnerability to physical harm; bridge housing should allow individuals to come and go, leave their belongings, arrange their own space, and count on having a place to return to
    - **Low barrier:** Subject to screening for current or past behaviors that would reasonably be viewed as posing a risk to program staff or other participants, housing or lodging should be offered and maintained regardless of criminal history, current drug use, or other behavioral health conditions
    - **Intensive Stabilization Support** ("meet people where they're at--but don't leave them there"): Low barrier doesn't mean accepting that people will just remain stuck in harmful patterns but will live indoors. That will doubtless be true for some and living inside is still preferable for them and for the surrounding community in nearly all cases. But, for most, intensive, trauma-informed on-site support can help to decrease ongoing trauma and vulnerability, create safety, allow the identification of barriers and trauma-based reactions, foster goal setting, increase hygiene, and work on barriers to housing, health, and economic stabilization, including legal system coordination for those who have active court obligations. Many individuals who, at entry, would have been assumed to need long term permanent supportive housing (PSH--an essential but costly kind of housing for people who need on-site support), can live independently with or without a housing subsidy in scattered-site units in the private housing market or in public housing. Intensive case management on-site in bridge housing or temporary lodging can facilitate optimal permanent housing placements as individuals move on.

**We recommend that the work is centered on people who use substances and/or experience mental health conditions who have lived/living experience with homelessness and/or housing instability, such as:**

- Individuals who encountered barriers in the shelter and homeless housing systems due to active drug use or being in recovery from substance use disorder

- Individuals who used shelter and/or homeless housing systems while actively using drugs or working on their recovery
- Individuals with expertise designing and operating bridge housing or temporary lodging for people with high barriers including current drug use
- Individuals with expertise bridging systems and designing systems to meet the needs of historically under-served populations
- Individuals with knowledge of current State investments in homelessness response
- Individuals with knowledge of Trueblood housing investments
- Individuals with knowledge of Continuums of Care/Coordinated Entry in homeless housing

**Bill Requirement(s)** – This recommendation meets several considerations for the Substance Use Recovery Services Plan:

*Bill requirement: Section 1(3)(a), (b), (e)*

### Concerns and Considerations

- In keeping with the broad SAMHSA definition of recovery, it's essential to engage and offer stabilization for individuals who aren't at a point that they can or will abstain from drug use, but whose harm to self and others can be reduced by providing secure and dignified non-congregate lodging, either permanent housing or "bridge housing," that permits intensive support teams to work with individuals to identify, address and shift barriers to recovery. Creating systems of engagement and care that presume traditional treatment, abstinence and/or sobriety, will, by definition, leave out huge numbers of those engaged in harmful drug use, diminish the perceived efficacy of the state's other investments, and will particularly miss most of those at highest exposure of law enforcement action and criminal legal system involvement. We must make a path for those who are currently using and not immediately ready to stop, to not be living in public, to live in comparative safety, and to have a strong support framework to begin to work on personal objectives, healing, and recovery (broadly defined). This is the logic behind Housing First.
- Placement in bridge/transitional housing often causes individuals to lose their homelessness status and therefore, their eligibility for many next step housing options. It will be important to explore barriers posed by homelessness definitions and possible solutions.
- Living in housing with individuals who are actively using can jeopardize the safety and well-being of those who are in early recovery. Therefore, it will be important to establish a full continuum of housing options to meet the needs of people who are in recovery or seeking recovery as well as those who are actively using. To protect other residents, many recovery homes have adopted a zero-tolerance approach to drug use. It will be important to explore ways that recovery homes can balance protecting the safety and recovery of all residents with providing an opportunity for individuals who have had a recurrence of use to stabilize and remain housed, including availability of crisis stabilization housing in the community that could provide interim housing for an

individual who is awaiting a bed at a withdrawal management/detox or inpatient facility or a return to the recovery home

- Expansion of Homeless Outreach services that represent their communities. We need to first reach the underserved and marginalized communities. Add additional funds to build peers for Homeless Outreach that represents BIPOC communities.

### Collaboration with Existing Resources:

#### *Currently Offered Housing Programs and Government Funding*

- [List of homeless shelters in Washington State by city/county](#)
- **HARPS and Trueblood Forensics HARPS:** Housing and Recovery Through Peer Services (HARPS) provides supportive housing services and short-term housing bridge subsidies to at risk individuals (people who are exiting, or at risk of entering inpatient behavioral healthcare settings).
- Through proviso 96 Expansion of Housing First services, HCA/DBHR/RSS is in the process of identifying 9 regions that will receive a grant.

### **SURSA committee feedback**

No feedback on this recommendation was provided from SURSAC members during the pre-meeting review period



Appendix S - Resources to inform a recommendation for the state's criminal-legal response to possession of controlled substances

# Substance Use Recovery Services Advisory Committee

Resources to inform a  
recommendation for the state's  
criminal-legal response to  
possession of controlled  
substances

Updated 06-27-2022

## Committee Charge

### 5476 Section 1

The authority, in collaboration with the substance use recovery services advisory committee established in subsection (2) of this section, shall establish a substance use recovery services plan. The purpose of the plan is to implement measures to assist persons with substance use disorder in accessing outreach, treatment, and recovery support services that are low barrier, person centered, informed by people with lived experience, and culturally and linguistically appropriate. The plan must articulate the manner in which continual, rapid, and widespread access to a comprehensive continuum of care will be provided to all persons with substance use disorder.

(3) The plan must consider:

(l) Recommendations regarding the appropriate criminal legal system response, if any, to possession of controlled substances

## Document Development

At the May 2<sup>nd</sup> SURSAC meeting, committee members were asked about what information would be helpful to have to formulate a recommendation for the appropriate criminal-legal response to possession of controlled substances, if any. The 5476 support team at HCA gathered several resources to meet those information requests, which were emailed to the SURSAC on Wednesday, June 1<sup>st</sup>. At the June 6<sup>th</sup> SURSAC meeting, there was a request to invite additional contributions. On June 6<sup>th</sup>, Michelle sent an email to all SURSAC meeting attendees titled, “SURSAC: Opportunity to add Criminal-Legal Response resources”, inviting contributions to this document by June 24<sup>th</sup>, so that the revised document could be shared June 27<sup>th</sup>, providing the SURSAC two full weeks to review before the July 11<sup>th</sup> meeting.

## Summary of Hyperlinked Resources

[Cannabis Legalization and Racial Disparities in Washington State](#)

[Drug Decriminalization in Oregon, One Year Later: Thousands of Lives not Ruined by Possession Arrests, \\$300 million+ in Funding for Services](#)

[Depenalization, diversion and decriminalization: A realist review and programme theory of alternatives to criminalization for simple drug possession](#)

[Drug decriminalization policy: Literature review: Models, implementation and outcomes](#)

[Drug Decriminalization | Drug Policy Alliance](#)

[Racial, Gender, and County Disparities for Simple Drug Possession Convictions in Washington State](#)

[Washington State Court Directory](#)

[Determination of Eligibility \(Therapeutic Courts\) – RCW 2.30.030](#)

[Drug Courts are not the answer: Toward a Health-Centered Approach to Drug Use \(Drug Policy Alliance, March 2021\)](#)

[America’s problem-solving courts: The criminal costs of treatment and the case for reform \(National Association of Criminal Defense Lawyers, September 2009\)](#)

[Addicted to courts: How a growing dependence on drug courts impacts people and communities \(Justice Policy Institute, March 2011\)](#)

[Drug Court Outcomes \(2013\)](#)

[Drug Court Participants: Recidivism and Key Outcome Measures \(DSHS\)](#)

[Chemical Dependency Treatment for Incarcerated individuals: A Review of the Evidence and Benefit-Cost Findings](#)

RNP: [Recovery Navigator Program \(Intercepts 0, 1\)](#)

[The Arrest and Jail Alternatives program](#)

[Seattle's Law Enforcement Assisted Diversion \(LEAD\) Program: Within-Subjects Changes on Housing, Employment, and Income / Benefits Outcomes and Associations with Recidivism](#)

[Seattle's law enforcement assisted diversion \(LEAD\) program effects on criminal justice and legal system utilization and costs](#)

[Seattle's Law Enforcement Assisted Diversion \(LEAD\): Program effects on recidivism outcomes](#)

[LEAD Program Evaluation: Describing LEAD case management in participants' own words \(Harm Reduction Research and Treatment Center, UW, November 2016\)](#)

[DOC Institutional Costs, Average Daily Population, and Cost Per Incarcerated Individual per Day \(FY2019\)](#)

[Hidden Consequences: The Impact of Incarceration on Dependent Children | National Institute of Justice](#)

[Cost-Benefit Analysis of public policies and programs](#)

[Peer Reviewed Research About Syringe Service Programs | Washington State Department of Health](#)

[County Profiles of Social Determinants of Health](#)

[Study after study shows ex-prisoners would be better off without intense supervision \(Brookings, July 2018\)](#)

[JustCARE: The development and impact of a multi-faceted collective impact model \(University of Washington, June 2021\)](#)

## Summary of Attachments

[A Quiet Revolution: Drug Decriminalization Across the Globe \(March 2016\)](#)

### Effects of Criminalization Key Points 2021 Update

[National Association of Drug Court Professionals \(NADCP\) Equity and Inclusion Research Brief: Exclusionary Criteria and Their Impacts on the Likelihood to Reoffend, Racial Bias, and Outcomes in Treatment Court](#)

[Racial Distribution of Drug Court Participants \(CJTA Panel July 31 2020\\_Racial Distribution\)](#)

[Drug Offender Sentencing Alternatives \(DOSAs\)](#)

[DOC Substance Abuse Recovery Unit \(SARU\)](#)

[Behavioral Health Agencies Directory](#)

[Behavioral Health Treatment Availability in Rural Counties](#)

**NOTE:** Hyperlinks are provided as often as possible for easy access to the resources included in this document. Resources that could not be hyperlinked are included as email attachments, noted with “ATTACHMENT”

### Drug Criminalization and Racial Disparities

Since Oregon is the first state in the nation to decriminalize (small amount) possession of controlled substances, and the law has only been in effect for one year, it will take time to understand the full racial impact of this policy in OR, and the potential impact for our own state if this policy were to be adopted in Washington State long-term. However, we can look at the racial impact of decriminalization – and the legalization of supply – related to cannabis to help us understand potential impacts.

#### [Cannabis Legalization and Racial Disparities in Washington State](#)

This report from ADAI (March 2019) examines publicly available data on **cannabis use and racial disparities in WA** in three areas of interest: criminal justice, youth consumption, and treatment for substance use disorders. The article notes:

“Before legalization, African American/Blacks were 2.8 times more likely to be arrested for marijuana possession than Whites, in Washington State (3.8 times nationwide). Most of these arrests (88%) were for cannabis-possession-only, yet adult marijuana use was similar across racial and ethnic groups.

After legalization, analysis from the Washington State University Crime, Cannabis and Police Research Group indicated that disparities between African American/Black and white adults varied by the type of crime committed. The relative disparity in arrests for selling marijuana has more than doubled since legalization while there was a small decrease in possession-related disparities.

The disparity in court filings for marijuana possession among African American/Black adults has remained unchanged after legalization. African American/Black adults are nearly three times more likely to be prosecuted for a low-level marijuana possession offense than white adults after legalization”

#### [Drug Decriminalization in Oregon, One Year Later: Thousands of Lives not Ruined by Possession Arrests, \\$300 million+ in Funding for Services](#)

This article from DrugPolicy.org, “[Drug Decriminalization in Oregon, One Year Later](#)” notes a *prediction* from the Oregon Criminal Justice Commission that Measure 110’s passage would result in a 95% reduction in racial disparities in drug arrests.”

ATTACHMENT: [A Quiet Revolution: Drug Decriminalization Across the Globe \(March 2016\)](#)

[Depenalization, diversion and decriminalization: A realist review and programme theory of alternatives to criminalization for simple drug possession](#)

[Drug decriminalization policy : Literature review: Models, implementation and outcomes](#)

[Drug Decriminalization | Drug Policy Alliance](#)

ATTACHMENT – [Effects of Criminalization Key Points 2021 Update](#)



This document provides support information for [HB 1499](#), offered by the Office of Infectious Disease (OID within DCHS) at the Washington State Dept of Health, which notes citations for the following findings:

- Criminalization negatively impacts racial justice and health equity
- Criminalization negatively impacts women and families
- Criminalization negatively impacts efforts to prevent and treat infectious disease among people who use drugs
- Criminalization contributes to overdose morbidity and mortality
- Criminalization is expensive and burdens the state budget
- Criminalization of paraphernalia for personal use impacts public health and safety efforts

### Conviction Rates for Possession of Controlled Substances

#### [Racial, Gender, and County Disparities for Simple Drug Possession Convictions in Washington State](#)

### Therapeutic Courts

#### [Washington State Court Directory](#)

Here you can find a list of all the therapeutic courts in Washington, which are generally available at Intercept 3 (Specialty Courts), including:

- Drug Courts
- Juvenile Courts
- Family Treatment
- Mental Health Court

#### [Determination of Eligibility \(Therapeutic Courts\) – RCW 2.30.030](#)

This statute lays out some statewide therapeutic court eligibility limitations. However, before those limits are reached, there are a lot of differences between counties in terms of what charges they take and what additional exclusionary criteria they apply. For example, some counties will not take drug delivery charges. And, nationwide, according to the National Association of Drug Court Professionals (NADCP), although White individuals are more likely to be involved in trafficking, Black individuals are more likely to be arrested for drug trafficking, so there could certainly be racial disparities that result from various eligibility decisions.

To understand why cases do not qualify, we'd need data from every county prosecutor, and it would involve digging into every case, which is an undertaking that we do not have capacity for. One other thing to note is that one of the main reasons people don't get offered drug court is that their defense attorneys don't request it – either because they don't know about it, don't believe in it, don't think it is the best possible deal, or don't think the case will be approved for entry by the prosecutor. In some cases, drug court may be disincentivized because attorneys may get better deals if their client will just plea mainstream. Defense guidance is a major reason why any individual would or would not end up in drug court, which makes it much harder to quantify than a situation where a prosecutor is actually denying a case entry.

The Administrative Office of the Courts (AOC) Behavioral Health Court Program is working on an assessment that will take a deeper dive into Treatment Court eligibility criteria, but the results of those reports and any court-specific data won't likely be available until mid-late 2023. Tessa Clemments (the AOC BH Court Program Lead) suggests looking at each court's policy and procedure manual to find their stated eligibility criteria.

[Drug Courts are not the answer: Toward a Health-Centered Approach to Drug Use \(Drug Policy Alliance, March 2021\)](#)

[America’s problem-solving courts: The criminal costs of treatment and the case for reform \(National Association of Criminal Defense Lawyers, September 2009\)](#)

[Addicted to courts: How a growing dependence on drug courts impacts people and communities \(Justice Policy Institute, March 2011\)](#)

- [The King County Drug Diversion Court Procedure and Policy Manual \(Eligibility begins on page 5\)](#)
- [National Association of Drug Court Professionals \(NADCP\) Equity and Inclusion Research Brief: Exclusionary Criteria and Their Impacts on the Likelihood to Reoffend, Racial Bias, and Outcomes in Treatment Court](#)
- [Racial Distribution of Drug Court Participants \(CJTA Panel July 31 2020\\_Racial Distribution\)](#)

### [Drug Court Outcomes \(2013\)](#)

Describes the criminal and CD treatment participation outcomes of 1,671 adults charged with felonies who were eligible for treatment, primarily funded through CJTA, and who were admitted to formally established drug courts. Three-year outcomes are compared to a statistically matched comparison group of 1,671 adults charged with similar felonies in the same jurisdictions and two-year time period (July 2007 through June 2009), but who were not admitted to a drug court. Arrests, incarceration rates, and treatment participation over a three-year follow-up period are examined, as are net benefits associated with reductions in crime.

- Drug Court Participants were less likely to be incarcerated during the follow-up period than individuals in the comparison group (17 versus 23 percent)
- Controlling for other factors leading to arrest, drug court participants were twice as likely to remain free of arrest as those in the comparison group (30 vs. 15 percent)
- Nearly universal participation in chemical dependency treatment was obtained by drug court participants (97 percent compared to 46 percent in the comparison group)
- Drug court participants were over 3 times more likely to enter treatment within 90 days and 4 times more likely to be in treatment – primarily outpatient – for 90 or more days
- Reductions in crime observed in this analysis translate into a net benefit to taxpayers and society of approximately \$22,000 per participant, or \$4.02 in benefits per dollar spent

### [Drug Court Participants: Recidivism and Key Outcome Measures \(DSHS\)](#)

These reports do not include reasons for arrest (they are not specific to arrests related to possession of controlled substance), but they do include [demographics, SUD treatment participation, recidivism, employment, and Medicaid enrollment among Drug Court enrollees.](#) These reports present recidivism measures and other key outcomes and characteristics of offenders participating in adult drug courts across Washington State. The reports contain yearly trends [for individual courts and for courts statewide.](#) The reports were written in collaboration with the Criminal Justice Treatment Account Panel and the HCA Division of Behavioral Health and Recovery, and will be updated annually. To protect client confidentiality, reports for courts with a small number of participants are not included.

- [King](#)
- [Kitsap](#)
- [Pierce](#)

- [Snohomish](#)
- [Spokane](#)
- [Thurston](#)

### Drug Offender Sentencing Alternatives Outcomes

#### [ATTACHMENT - Drug Offender Sentencing Alternatives \(DOSA\)](#)

The Fact sheet including [demographic](#) and [county](#) data for the DOSA program (attached), designed to provide SUD treatment and community supervision for individuals diagnosed with an SUD who have committed a drug or other statutory eligible crime. Individuals sentenced to a DOSA are required to participate in SUD treatment in lieu of prison time, or a reduced prison sentence.

### SUD Treatment Programs and Outcomes for Incarcerated Individuals

#### [ATTACHMENT - DOC Substance Abuse Recovery Unit \(SARU\)](#)

The DOC Substance Abuse Recovery Unit is one of the largest certified treatment agencies in the State of Washington, with services located in 11 of 12 state prison facilities (as of July 2021) and nine work release locations. The Washington State Institute for Public Policy found that incarcerated individuals who participate in Substance Use treatment programs have lower recidivism rates than those who did not participate by 4 to 9 percent.

The SARU statistics document (attached) outlines the SUD treatment recovery programs available to incarcerated individuals and provides some data by gender but not by race.

#### [Chemical Dependency Treatment for Incarcerated individuals: A Review of the Evidence and Benefit-Cost Findings](#)

In this The Washington State Institute for Public Policy found that for each dollar spent on drug treatment in confinement and partial confinement there is a taxpayer benefit ranging between \$5.05 to \$13.91 (depending on level of care and sentencing type).

### Diversion Programs for Youth and Adults

#### [RNP: Recovery Navigator Program \(Intercepts 0, 1\)](#)

The intent of the RNP is to provide behavioral health services to individuals who intersect with police because of simple drug possession, people who have frequent criminal-legal system contact, and others who are referred from community sources. These programs are to serve people who are at risk of arrest, or already have been involved in the criminal legal system due to unmet behavioral health needs.

- [Fact Sheet](#)
- [Uniform Program Standards](#)
- [RCW 71.24.115](#)

#### [AJA: Arrest and Jail Alternatives Grant Program](#)

[The Arrest and Jail Alternatives program](#) was established per [HB 1767](#), [RCW 36.28A.450](#), and created a partnership between WASPC and the LEAD National Support Bureau, to develop and implement a grant program aimed at supporting local initiatives to properly identify criminal justice system-involved persons with substance use disorders and other behavioral health needs and engage those persons with therapeutic interventions and other services. Grants for this work have been provided to the following 3 organizations:

- Catholic Community Services (Olympia)
- Olympic Peninsula Community Clinic (Port Angeles)
- Comprehensive Healthcare (Walla Walla)

[Click here for the AJA 2021 Annual Report.](#)

### LEAD in Seattle/King County

Seattle's Law Enforcement Assisted Diversion (LEAD) program is the first known pre-booking diversion program for people arrested on narcotics and prostitution charges in the United States. Launched in October 2011, LEAD is the product of a multi-year collaboration involving a wide range of organizations, including The Defender Association's Racial Disparity Project, the Seattle Police Department, the ACLU of Washington, the King County Prosecuting Attorney's Office, the Seattle City Attorney's office, the King County Sheriff's Office, Evergreen Treatment Services, the King County Executive, the Washington State Department of Corrections, and others.

[Seattle's Law Enforcement Assisted Diversion \(LEAD\) Program: Within-Subjects Changes on Housing, Employment, and Income / Benefits Outcomes and Associations with Recidivism](#)

[Seattle's law enforcement assisted diversion \(LEAD\) program effects on criminal justice and legal system utilization and costs](#)

[Seattle's Law Enforcement Assisted Diversion \(LEAD\): Program effects on recidivism outcomes](#)

[LEAD Program Evaluation: Describing LEAD case management in participants' own words \(Harm Reduction Research and Treatment Center, UW, November 2016\)](#)

### HCA LEAD Expansion Pilot Program

Per [SSB5380 Sec. 29](#), the Health Care Authority partnered with the Public Defender's Association and LEAD National Support Bureau to expand availability of LEAD programs statewide / outside King County. In 2020, HCA contracted with four different sites (\$4.1 million total) to provide and implement LEAD programs in the following counties, which receive technical assistance from PDA's National Support Bureau:

- Whatcom
- Snohomish
- Mason
- Thurston

### Cost and Benefits of Incarceration vs. Community-Based Harm Reduction and Treatment Programs

#### Fiscal Cost of Incarceration

[DOC Institutional Costs, Average Daily Population, and Cost Per Incarcerated Individual per Day \(FY2019\)](#)

Does not include MOUD, SUD-treatment specific, or other healthcare specific expenses, but provides a snapshot of total cost to incarcerate someone

### Social Cost: Impact on Children of Incarcerated Parents

#### [Hidden Consequences: The Impact of Incarceration on Dependent Children | National Institute of Justice](#)

Discusses “cost” of incarceration in terms of the impact on the children of incarcerated parents, which disproportionately impacts communities of color.

“One consequence of this dramatic increase is that more mothers and fathers with dependent children are in prison. Since the war on drugs began in the 1980s, for example, the rate of children with incarcerated mothers has increased 100 percent, and the rate of those with incarcerated fathers has increased more than 75 percent.”

“Data from 2007 (the most recent data available) show that African-American children and Hispanic children were 7.5 times more likely and 2.3 times more likely, respectively, than white children to have an incarcerated parent.”

#### [Cost-Benefit Analysis of public policies and programs](#)

This report from RDA includes several diversion and community-based treatment programs:

- Drug Offender Sentencing Alternative (for persons convicted of drug offenses)
- Case management (“swift, certain, and fair”) for drug-involved persons
- Mental health courts
- [Drug Courts](#)
- Inpatient or intensive outpatient drug treatment during incarceration
- Therapeutic communities (in the community) for individuals with co-occurring disorders
- Drug Offender Sentencing Alternatives (for persons convicted of property offenses)
- [Outpatient or non-intensive drug treatment during incarceration](#)
- Outpatient or non-intensive drug treatment in the community
- Housing assistance without services
- Housing assistance with services
- Police diversion for low-severity offenses (pre-arrest)
- Police diversion for individuals with mental illness (pre-arrest)

#### [Peer Reviewed Research About Syringe Service Programs | Washington State Department of Health](#)

“These analyses indicate that it would be highly cost-saving to invest additional funds to expand syringe exchange services in the US.”

### Community Behavioral Health Services

### Social Determinants of Health by County

This report includes data by county including:

- Drug Trafficking Zone
- Drugs deaths per 100,000
- Opioid hospitalizations per 100,000
- Opioid deaths per 100,000
- Mental health providers per 100,000
- Specialist providers (e.g., gastroenterology, hepatology, infectious disease, addiction medicine) per 100,000
- HIV cases per 100,000
- HCV cases per 100,000

### [ATTACHMENT - Behavioral Health Agencies Directory](#)

Attached is the DOH's [Behavioral Health Agency Directory](#), which includes information about the number of behavioral health agencies in each county, and what services they provide (Mental Health, SUD, or both). The patient capacities of the agencies are not listed.

### [ATTACHMENT - Behavioral Health Treatment Availability in Rural Counties](#)

Also attached is an excel spreadsheet that summarizes the BH agencies in Washington's rural counties, alongside recent population and population growth rate data, to provide a starting point for identifying areas that are under-resourced with behavioral health services provided through these agencies.

### **Additional Resource Contributions**

[Study after study shows ex-prisoners would be better off without intense supervision \(Brookings, July 2018\)](#)

[JustCARE: The development and impact of a multi-faceted collective impact model \(University of Washington, June 2021\)](#)

## Appendix T – RDA evaluation recommendation

## Evaluation Recommendations for the Blake-bill Interventions

JUNE 30, 2022

**Background**

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The Healthcare Authority (HCA) Division of Behavioral Health and Recovery (DBHR) requested an evaluation plan for selected programs targeting the population of individuals who are the focus of Blake Bill (SB 5476). *Blake-bill Interventions* are programs intended to provide treatment and support services to individuals who may have otherwise been subject to criminal prosecution, pre-Blake. The following programs are the focus of the evaluation recommendations provided by the Department of Social and Health Services (DSHS) Research and Data Analysis Division (RDA):

- **Recovery Navigator Program (RNP):** A statewide (~50-site) effort in partnership with Behavioral Health Administrative Organizations (BH-ASOs), the RNP provides community-based outreach, intake, assessment, and connection to services for youth and adults with substance use and co-occurring—SUD and mental health—disorders.
- **Medication for Opioid Use Disorder (MOUD) in Jails:** In nineteen participating facilities, incarcerated individuals will be assessed for an opioid use disorder (OUD) and offered medication for OUD where indicated. MOUD will be provided throughout the period of incarceration and individuals will be connected to continuing treatment after release or transfer to another facility.
- **Peer-Run and Clubhouse Services Expansion:** This is an expansion (of 10 sites) of Clubhouse International and Peer Run organizations, including organizations incorporating evidence-based models such as Clubhouse International, Recovery Community Organizations, and Recovery Cafes.
- **Homeless Outreach Stabilization Transition (HOST) Expansion:** This is an expansion of the existing HOST programs (of 5 sites). HOST is an outreach-based multidisciplinary approach intended to provide medical, behavioral, peer, and case management services to high-acuity individuals with substance use and co-occurring disorders who do not access existing services.

- **Substance Use Disorder Family Navigators:** This program (3 sites) supports parents, partners, and other adult family members of youth and young adults experiencing SUD-related challenges in navigating systems of care. Services to adult family members are provided by trained and certified family-support peers and include one-to-one peer coaching, socialization, peer group support, education groups, employment support, supportive housing, and referrals.

While each of these programs focuses on different services, settings, and individuals, and has different immediate aims (such as the provision of MOUD in jails or peer support services), the expectation is that they all will achieve, to differing degrees, the following common outcomes:

- Reduce criminal justice involvement,
- Reduce the use of emergency medical services and hospitalizations,
- Increase the use of behavioral mental health and SUD treatment, and
- Improve indicators of well-being such as access to primary care, employment, and housing.

The RDA-recommended evaluation strategy will focus on efficiently estimating the impact of each Blake Intervention on the above outcomes to inform decision makers about their overall and relative effectiveness. RDA is recommending a general analysis of outcomes broadly applicable to all Blake Interventions; program-specific strategies/outcomes may be further developed with input from the evaluator, RDA, program staff, and other individuals designated by HCA. These recommendations do not address routine performance monitoring or other important elements of program evaluation such as fidelity measurement or qualitative descriptions of the interventions. If such activities are not subsumed by HCA program managers or those implementing the programs, HCA may consider contracting with an entity specializing in these tasks.

### Recommended Evaluation Design and Research Questions

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***Quasi-Experimental Design.*** To efficiently estimate the effectiveness of the Blake Interventions, we recommend a strategy that employs similar methods across the programs and focuses on a common set of relevant outcomes. For a variety of reasons, random controlled trials—the research “gold-standard” for determining effectiveness—are not an option for evaluating the Blake Interventions. Instead, RDA recommends a quasi-experimental, longitudinal design, an evaluation approach frequently employed by RDA which leverages the extensive, person-level, longitudinal data available in the RDA-curated



Integrated Client Databases (ICDB).<sup>40</sup> The ICDB contains more than two decades of service risks, history, costs, and outcomes. The data systems span multiple state agencies, including DSHS, HCA, Department of Corrections (DOC), Employment Security Department (ESD), Department of Commerce, the Washington State Association of Sheriffs and Police Chiefs (WASPC), and the Washington State Patrol (WSP).<sup>41</sup> The quasi-experimental approach will allow for the consistent and reliable estimation of program impacts without imposing burdensome data collection requirements on providers and clients.

**Study Populations.** The quasi-experimental evaluation will compare the outcomes of service recipients “enrolled” in each intervention (treatment group) with the experiences of statistically similar individuals who were not enrolled in the intervention (comparison group) and then draw inferences about the effectiveness of a specific intervention. The treatment groups will include anyone enrolled in a particular Blake Intervention.<sup>42</sup> The definition of “enrollment” will vary depending on the intervention. In general, clients will be considered enrolled when they receive measurable service provided by a given intervention (e.g. for the MOUD in Jails program, this may be the day a client was inducted on to MOUD; for RNP, this may be the day they were assigned a navigator). Membership in the treatment group will be based on *intent-to-treat* rather than whether or not an individual “completed” a program.<sup>43</sup>

The comparison groups will include statistically matched samples from the relevant populations of individuals who qualify for each intervention, but were not enrolled during the study period.<sup>44</sup> In addition to selecting on qualifying criteria for each type of intervention program, members of the comparison groups will be identified using one or more of a variety of propensity score matching approaches to ensure equivalency in relevant characteristics between the treatment and comparison groups. Table 1 lists the possible matching criteria to be used to identify comparison groups.<sup>45</sup>

TABLE 1  
Proposed Matching Criteria

<sup>40</sup> Cite example reports.

<sup>41</sup> For more information about the ICDB, see <https://www.dshs.wa.gov/ffa/rda/research-reports/dshs-integrated-client-databases>.

<sup>42</sup> In the case of the SUD Family Navigator program, the service recipient may be a parent, but the enrolled individual will be the youth with or at-risk of an SUD.

<sup>43</sup> An intent-to-treat analysis ignores non-compliance to an assigned protocol and does not require collection of additional information on days of treatment or “graduation.” Fisher LD, Dixon DO, Herson J, Frankowski RK, Hearron MS, Peace KE. Intention to treat in clinical trials. In: Peace KE, editor. Statistical issues in drug research and development. New York: Marcel Dekker; 1990. pp. 331–50.

<sup>44</sup> Criteria for selecting the relevant qualified populations will be determined in collaboration with program managers and providers and in consideration of the data available in the ICDB.

<sup>45</sup> Rosenbaum, P. R. and D. B. Rubin. 1983. The central role of the propensity score in observational studies for causal effects. *Biometrika* 70(1): 41–55.

Characteristics	Variables
Demographics	Age, race, ethnicity, gender
Household Characteristics	Number of adults, minors, children under 12
Geography	County of residence, urbanicity
Criminal History	Prior arrests, charges, and convictions (by type), periods of incarceration (DOC), days in jail
Behavioral Health	Mental health and SUD diagnoses
Behavioral Health Service History	Outpatient mental health treatment, inpatient mental health treatment, withdrawal management, outpatient SUD treatment, inpatient SUD treatment, medication-assisted treatment
Health (general)	Medical risk score, chronic disease diagnoses, access to primary care
Emergency Department (ED) Usage and Hospitalizations	ED outpatient visits, non-ED outpatient visits, inpatient admissions
Housing Status	Homeless or unstably housed, housing services
Social Services and Other Assistance	Child welfare, SSI/SSDI, SNAP, TANF, HEN
Employment History	Quarters employed, earnings

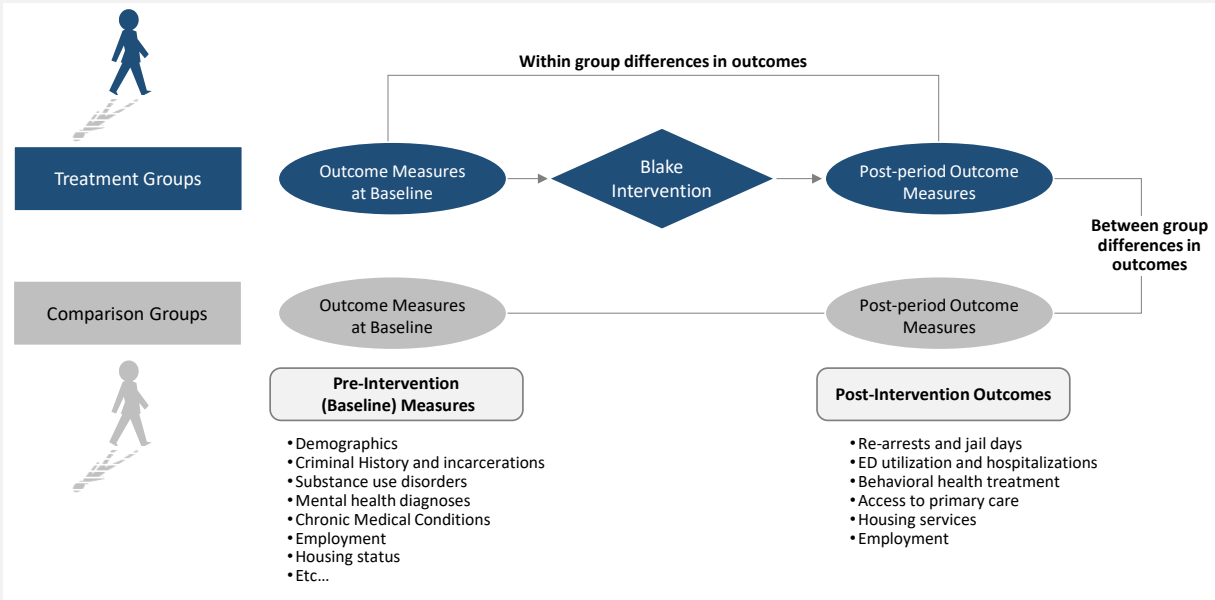
**Analysis.** With the exception of caveats noted below in Limitations and Considerations, the observed differences in outcomes between matched treatment and control groups will be attributed to the relevant intervention. A schematic of the research design is presented in Figure 1.

In addition to its use in the construction of treatment and comparison groups, the longitudinal ICDB data will support the necessary pre-tests of equivalence between the treatment and comparison groups regarding the outcomes to be measured. A longitudinal design will also support multiple measures of program outcomes, which will be the basis of the primary research questions. For each specific outcome, the proposed design will characterize outcomes in the following ways:

- **Within-Group:** a pre-post analysis of the treatment group that examines participant outcomes before and after the intervention (e.g. for individuals in a treatment group, what are the differences in arrest rates in the year before the intervention compared to the year after);
- **Between-Group:** post-period comparisons of treatment and comparison group outcomes in the follow-up period (e.g. during the year after the intervention, what are the differences in arrest rates between treatment and comparison groups); and

- **Difference-in-Difference:** this approach compares of the rates of change in outcomes, pre-post, experienced by the treatment and comparison groups (e.g. in the years before and after the intervention, what are the differences in the rates of change in arrests between the treatment and control groups).

FIGURE 1  
Research Design



**Outcome Measures.** The bases for specific outcomes to be examined in the proposed analyses—all which are available in the ICDB—are described in Table 2.

TABLE 2  
Blake Intervention Outcome Measures

Objective	Basis of Outcome Measure	ICDB Source
Reduce Criminal Justice Involvement	Arrests	WSP
	Days in Jail or DOC Facilities	HCA, WASPC, and DOC
Reduce Utilization of Emergency Physical and Behavioral Health Services	ED Visits	HCA
	Hospitalizations (Physical)	HCA
	Community and State Psychiatric Hospitalizations	DSHS
	Withdrawal Management	HCA
	Crisis Services	HCA
Increase use of Behavioral Health Services	SUD Outpatient Treatment	HCA
	SUD Inpatient Treatment	HCA
	Medication for SUD	HCA
	Outpatient Mental Health Treatment Services/Medication	HCA
	Employment and Earnings	ESD

## SUBSTANCE USE AND RECOVERY SERVICES PLAN

Improve Indicators of Well-being	Housing Services Utilization	Commerce
	Utilization of Primary Care	HCA
	Connection to Social Services (TANF, SNAP, HEN, DVR, etc.)	DSHS

The specific construction of each outcome measure (e.g. number of arrests per year, arrest rates, felony arrests, months of SUD treatment, etc.) will be determined in collaboration with the evaluator, RDA, program staff, and other individuals designated by HCA. Baseline descriptions of program participants and propensity score matching will be possible as soon as a sufficient number of clients are enrolled in any given program.<sup>46</sup>

**Post-period Definition.** The rigorous outcomes evaluation activities described here will require sufficient time post-enrollment for relevant outcomes to occur, to be reported to administrative data systems, and then updated in the ICDB. Typically analyses of this type employ 12- to 18-month pre- and post- periods to characterize outcomes (e.g. the number of arrests in the 12 months before an intervention and the number of arrests in the 12 months after the intervention). The time periods to be used in these analyses will depend on reporting deadlines (nearer-term deadlines will mean that the evaluation will be based on shorter post periods); implementation schedules (earlier implementation will allow for longer post periods); and lags in the availability of data for specific outcome measures (e.g. there is a 6-month lag in employment outcomes; conviction outcomes are omitted from this proposal because of the time required for adjudication). Relevant time periods will be determined by the evaluator in concert with the specific definitions of outcome measures described above. It is possible that there will be different time periods used for each intervention and measure.

**Index Month.** A critical concept in developing the evaluation analytics is the *index month*. The index month in this context is the month in which we consider an individual to be under the influence of a particular intervention. This may be the month they are first inducted onto MOUD in a jail or the month they were assigned a recovery navigator. In collaboration with program staff, the evaluator will determine the relevant definition of the index month for each Blake Intervention. Once established, all measurement concepts associated for a given analysis will be based on events or characteristics manifesting in the relevant months before and after the index month. RDA recommends using an index month (rather than a specific index date or index year) because most data in the ICDB are organized by

<sup>46</sup> The “sufficient” number of participants will depend on the expected effect size of any given intervention. Interventions expecting large effect sizes require small samples.

monthly intervals. If the evaluator determines that more refined definitions are required, there will be additional costs associated with having RDA organize the data accordingly.

### Data Collection

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As previously noted, the recommended evaluation approach will rely almost exclusively on existing data curated by RDA in the ICDB. In collaboration with the evaluator, RDA will create person-level analytic datasets with all the necessary (and available) variables. To support the proposed evaluation, it will be necessary for the service providers to collect and maintain the following information on each client served:

- First name
- Last name
- Middle initial
- Date of birth
- SSN if available
- A ProviderOne ID is acceptable in place the above identifiers
- Enrollment Date (there may be multiple enrollments in some cases)

HCA program managers should work closely with service providers and RDA to ensure this information is routinely and systematically collected and maintained in a medium that supports the efficient transmission of data to HCA or RDA by secure means. Data collection by the individual Blake Interventions varies by program. Some programs collect information on disparate spread sheets; others, such as the RNP, utilize sophisticated case management software. Future opportunities for informative sub-group analyses on the relative effectiveness of different intervention service components may be possible for programs that collect sufficient additional information on their clients.

### Limitations and Other Considerations

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***Medicaid Enrollees.*** The recommended evaluation approach relies exclusively on data compiled by RDA in the ICDB. The most complete data in the ICDB are for individuals who are enrolled in Medicaid, therefore most analyses will be restricted to Medicaid clients. We expect the majority of clients participating in the Blake Interventions will be Medicaid-enrolled.

***Institutional Review Board.*** Whomever is tasked with performing an evaluation of the Blake Interventions will be responsible for submitting a research application or exempt determination to the Washington State Institutional Review Board and coordinate with RDA on the necessary data request.

**Client Identifiers.** HCA program managers should prioritize the collection of the client-level data describe above and ensure that providers are able to collect and share the relevant data in a timely and efficient fashion. This may require contract amendments that require this data collection and that include language allowing data sharing of client identifiers with RDA. Interventions that are unable to provide this information will need to be evaluated by alternative means beyond the scope of this proposal.

**Sample Size.** The recommended evaluation approach may not be feasible for interventions that enroll too few clients linked with the ICDB to generate meaningful results. In such cases, it may only be possible to provide baseline characteristics of clients served and descriptive pre-post outcomes (without a comparison group), which are of limited value.

**Unobservable Characteristics.** Propensity score matching reduces biases associated with observed characteristics and experiences between the treatment and comparison groups. It does not, however, cannot control for unobserved characteristics such as an individual's motivation to participate in behavioral health treatment. As such, it is not possible to guarantee unbiased results in the prosed outcomes analyses.

**Applicability.** This recommended evaluation approach is purposely general and applicable to all of the Blake Interventions. For some programs, however, the client-level analyses described above may not provide actionable intelligence. For instance, programs that simply expand existing services—e.g. HOST—may not benefit from an evaluation of outcomes for clients served only by the expansion. In such cases, it might be more informative to report on the status of the expansion efforts, the number and type of clients served, and the fidelity to which the expansion holds to the established model.

Appendix U – Current state programs

# Current State-Administered Substance Use Recovery Support Services

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STATE PLANS

SOORP: State Opioid and Overdose Response Plan  
*Kris Shera*

The executive sponsors for this plan are responsible for approving and overseeing the implementation of the plan. They include:

- Charissa Fotinos (HCA)
- Michael Langer (HCA DBHR)
- Caleb Banta-Green (UW ADAI)
- Tao Kwan-Gett (DOH)

**FACT SHEET**

**Full SOORP PDF**

Roadmap to Recovery Planning Grant  
*Kris Shera*

Housing Action Plan  
*Michael Donovan*

SUBSTANCE USE PREVENTION and YOUTH ENGAGEMENT

Washington Healthy Youth (WHY) Coalition  
*Martha Williams*

**FACT SHEET**

The coalition represents more than 15 state agencies and organizations and focuses on:

- Promoting changes in industry policy and practices
- Educating policy makers on prevention issues and best practices
- Monitoring impacts of policy on prevention
- Supporting prevention efforts through development and distribution of educational materials and resources
- Increasing statewide education, collaboration, and partnerships to reduce youth access to alcohol and marijuana use

### School-based Prevention and Intervention Services

*Carola Brenes*

#### FACT SHEET

In 1989, the Washington State Legislature passed the Omnibus Alcohol and Controlled Substances Act authorizing state agencies to conduct a variety of programs addressing the public's concern about the level and consequences of alcohol, tobacco, and other drug use. As a result, the Student Assistance Prevention and Intervention Services Program (SAPISP), with a mix of local, state, and federal funds, places prevention and intervention specialists in schools to implement comprehensive student assistance programs addressing problems associated with substance use and violence. SAPISP funds are distributed to each of the state's nine Educational Service Districts (ESDs) as part of the Community Prevention and Wellness Initiative (CPWI). Funding amounts are allocated to ESDs to support 80% of one full-time position in each of the nearly 100 CPWI communities. The CPWI communities or school districts provide a 20% match to support the prevention intervention specialist positions.

### Suicide Prevention and Mental Health Promotion

*Jen Hogge*

#### FACT SHEET

The Health Care Authority (HCA) Division of Behavioral Health and Recovery (DBHR) funds Community Prevention and Wellness Initiative (CPWI) coalitions as well as local community-based organizations, private not-for-profits, and educational organizations for mental health promotion or suicide prevention services. These communities implement a variety of mental health promotion or suicide prevention programs. Programming includes both school and community based services, including the use of evidence-based programs such as PAX Good Behavior Game, Second Step, Sources of Strength, Guiding Good Choices, Primary Project, and QPR Gatekeeper Training that are effective at promoting mental health and/or preventing suicide. Communities also provide Youth Mental Health First Aid trainings and mental health and suicide prevention community awareness events. DBHR also facilitates an ongoing mental health promotion/suicide prevention workgroup as part of the State Prevention Enhancement Consortium. The workgroup was organized in March 2013 and meets 6-12 times per year to support the work of the consortium.

### State [SUD] Prevention Consortium and Plan

*Alicia Hughes, CBO and Grants Supervisor, SUD Prevention and MH Promotion Section*

## FACT SHEET

The SPE Policy Consortium designs and implements the five-year Washington State Prevention Strategic Plan. The Consortium is working to strengthen and support an integrated statewide system of community-driven substance use disorder prevention, mental health promotion, and related behavioral health issues. Twenty-six state agencies and organizations and tribal partners represented the Consortium with more than 45 active members. The 2019 State Substance Use Disorder Prevention and Mental Health Promotion Plan is implemented by five workgroups that meet on a regular basis and in cooperation with statewide agencies have some focus on prevention and mental health promotion. The following workgroups oversee the implementation of action plans to accomplish the goals and mission of the plan:

The Washington Healthy Youth Coalition: Underage drinking and marijuana misuse/abuse prevention  
[www.starttalkingnow.org/about-us](http://www.starttalkingnow.org/about-us)

Opioid Prevention Workgroup: <https://www.theathenaforum.org/rx>

Young Adults Alcohol and Marijuana Misuse/Abuse Prevention Workgroup:  
<https://www.theathenaforum.org/marijuana>

Commercial Tobacco and Vapor Products Workgroup: <https://www.theathenaforum.org/tobacco>

Mental Health Promotion and Suicide Prevention Workgroup:  
<https://www.theathenaforum.org/mentalhealth>

In 2011, the Consortium initiated the strategic planning process to develop a Five-Year Strategic Plan for 2012-2017. The Consortium used the Prevention Planning Framework, based on the Strategic Prevention Framework (SPF), as the overall planning framework for this process. The SPF was originally developed by the federal Substance Abuse and Mental Health Services Administration (SAMHSA). SAMSHA's SPF is a comprehensive planning process designed to help states and communities build the infrastructure necessary for effective and sustainable prevention. The Consortium updates the Strategic Plan every five years, with the last major update being the 2017-2022 plan. In November 2019, a needs and resources assessment was completed and the Plan was updated at this time. The most recent version can be found at: <https://www.theathenaforum.org/substance-use-disorder-prevention-and-mental-health-promotion-five-year-strategic-plan>

WA SPF Rx: WA Strategic Prevention Framework for Prescription Drugs  
*Alicia Hughes*

## FACT SHEET

The HCA's Division of Behavioral Health and Recovery (DBHR) will lead efforts to address the risks misusing prescription drugs by implementing a collaborative strategic plan that will include prevention campaign messaging, evidence-based prevention education, prescriber education, and increased utilization of the Prescription Monitoring Program (PMP).

CPWI: Community Prevention and Wellness Initiative  
*Kasey Kates*

### CPWI Fact Sheet

The Community Prevention and Wellness Initiative (CPWI) is a community-focused approach to preventing substance abuse in Washington State. It focuses Washington's limited public resources in nearly 100 high-need communities

Emergency Response Suicide Prevention Grant

*Jen Hogge*

### FACT SHEET

The Health Care Authority (HCA) Division of Behavioral Health and Recovery (DBHR) funds the University of Washington Medical Center (UWMC) Department of Psychiatry and Behavioral Sciences Behavioral Health Institute (BHI) to support adults, 25 and older, who have attempted suicide or experienced a suicidal crisis. The essential activities of the grant include:

Develop and implement a plan for rapid followup for adults after discharge from emergency departments and inpatient psychiatric facilities.

Establish follow-up and care transition protocols to help ensure patient safety.

Provide, or assure provision of, suicide prevention training to community and clinical service providers and systems serving adults at risk.

Provide suicide screening and assessment and appropriate referral for clinical treatment services required identified in the assessment.

Provide enhanced services for domestic violence survivors and their dependents including a safe place to stay if individuals are unable to remain safely in the home setting

Prescription Drug/Opioid Prevention

*Alicia Hughes*

### FACT SHEET

To address the opioid crisis in Washington State, The Health Care Authority's Division of Behavioral Health and Recovery (HCA/DBHR) and partnering agencies support opioid and prescription medication prevention strategies that align with the Washington State Opioid and Overdose Response Plan.

<https://www.hca.wa.gov/assets/program/WashingtonStateOpioidandOverdoseResponsePlan-final-2021.pdf>

Prevention Workforce Development

*Sonja Pipek*

### FACT SHEET

The Health Care Authority's Division of Behavioral Health and Recovery (DBHR) has contributed to expanding the reach and impact of prevention services in throughout the state. DBHR provides opportunities for new and current prevention providers to continue their education, as well as opportunities for high school and college students to train into prevention via our Fellowship and

Internship programs. DBHR allows prevention professionals to earn their Certified Prevention Professional (CPP) to continue to elevate the field of prevention in the continuum of behavioral health services.

### *OUTREACH, CRISIS RESPONSE, and SERVICE ENGAGEMENT*

Washington Recovery Helpline: 1-866-789-1511

*Ryan Keith*

### FACT SHEET

The Washington Recovery Help Line (the Help Line) is a statewide telephone service and website that is available 24 hours a day, 365 days a year: 1-866-789- 1511 and [www.warecoveryhelpline.org](http://www.warecoveryhelpline.org). The Help Line provides information, referrals, online educational resources, and emotional support, along with a listing of behavioral health job openings and resumes and a quarterly newsletter.

A Medication Assisted Treatment Locator Database is available on the Help Line website, providing clients, community members, and professionals with information on where FDA-approved Medications for Opioid Use Disorder (e.g., Methadone, Naltrexone, Buprenorphine) are available in local communities. As of October 2021, it lists 644 clinics/programs and 2,852 individual prescribers of MOUD.

The Help Line provides services to:

Behavioral health professionals, primary health care providers, employers, and other referral sources.

Parents, other family members, friends and others seeking information about how to intervene with someone who needs help.

People seeking assessment/treatment for themselves.

[988 Behavioral Health Crisis Line and Mobile Crisis Services](#)

Matt Gower

HB 1477, the Crisis Call Center Hubs and Crisis Services Act, enhances and expands behavioral health crisis response and suicide prevention services for all people in Washington State. The work is supported by recommendations from the Crisis Response Improvement Strategy (CRIS) committee. The 988 dialing code will be available nationally for call, text, or chat beginning July 15, 2022. Increased collaboration between crisis service providers aims to reduce the use of emergency room and police departments, while increasing options for those in crisis and improving system coordination around access to care.

### [988 Crisis Line Implementation](#)

### [Crisis Response Improvement Strategy \(CRIS\) committee](#)

[Native and Strong Lifeline](#) is a line dedicated to serving American Indian and Alaska Native individuals calling the 988 crisis line, working in partnership with the Indian Behavioral Health Hub, a resource support line for tribes, urban Indian organizations, families, and non-tribal providers who support tribal

and urban Indian communities to identify resources and follow up with those accessing the 988 crisis line

IMC Engagement and Outreach behavioral health coverage

[Service Encounter Reporting Instructions \(SERI\), published April 2022](#) >> Engagement and Outreach (page 140)

PATH: Projects for Assistance in Transition from Homelessness

Lisa Bennet Perry

### [PATH Fact Sheet](#)

Peer Pathfinder

Lisa Bennett-Perry

### [FACT SHEET](#)

The Peer Pathfinder Projects build on the already established DBHR Projects for Assistance in Transition from Homelessness (PATH) program to provide substance use disorder (SUD) peer recovery support in emergency rooms and homeless encampments. The project links individuals to treatment options to include Medication for Opioid Use Disorder (MOUD). In Washington State, SUD peer counseling is an approved Medicaid service. Peer counseling is provided by certified peer counselors who have met state requirements, taken the approved classes, and passed the state test. Peer counselors use their own recovery stories in helping others develop hope and improve their lives. Peer Pathfinder SUD Peers assist individuals in navigating and obtaining services to address barriers to independence and recovery. These services address housing, financial resources, transportation, habilitation and rehabilitation services, prevocational and vocational services.

#### **Eligibility**

Adults (age 18 or over), with one of the following conditions:

Individuals with Opioid Use Disorders (OUD) or

Stimulant Use Disorder (SUD) at risk of overdose or

Individuals who are suspected of Substance Use and who may be experiencing homelessness or who are at risk of homelessness or

Individuals experiencing a substance use health crisis and are utilizing emergency room settings

[Peer Pathfinder – Homeless Outreach \(opioid use target\)](#)

Lisa Bennett-Perry

### [FACT SHEET](#)

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Individuals experiencing a substance use health crisis and are utilizing emergency room settings

[HOST: Homeless Outreach Stabilization Transition \(HOST\) expansion](#)  
Meta Hogan

### **HOST Fact Sheet**

The Homeless Outreach Stabilization and Transition (HOST) program provides outreach-based treatment services to individuals with serious behavioral health challenges including substance use disorder (SUD). Multidisciplinary teams can provide SUD, medical, rehabilitative, and peer services in the field to individuals who lack consistent access to these vital services.

HOST eligibility means that an individual has a behavioral health challenge, which can include SUD with or without co-occurring mental illness, that is untreated, under-treated or undiagnosed, and is experiencing literal or chronic homelessness. HOSTeligible individuals will also be experiencing behavioral health symptoms that create a barrier to accessing and receiving conventional behavioral health services and outreach models

### **LOCATIONS**

In SFY22, the HCA's Division of Behavioral Health and Recovery (DBHR) will contract four Behavioral Health Administrative Services Organizations covering five regional service areas:

- King County
- Southwest Washington
- North Sound
- Pierce
- Thurston Mason



The BH-ASOs subcontract HOST services to licensed community behavioral health agencies. DBHR also contracts with the Downtown Emergency Services Center to provide technical assistance to HOST providers

SSP: Syringe Service Programs (DOH)

Chelsie Porter

### [SYRINGE SERVICE PROGRAMS – DOH program info page](#)

Syringe Service Programs provide supplies for safer drug use to prevent health issues including infectious disease, skin and soft tissue infections, and overdose, as well as other services including:

Outreach and engagement for people who use drugs;

Infectious disease testing/treatment

Low barrier medications for opioid use disorder

Overdose education and naloxone distribution

Case management

Vaccinations

Wound care

Reproductive health

[Overdose Education and Naloxone Distribution \(DOH\)](#)

*Sean Hemmerle (DOH), Sue Green (HCA)*

### [DOH Program Info web page](#)

### [FACT SHEET](#)

Program that offers free naloxone kits, overdose response training and technical assistance to organizations interested in distributing naloxone to people at risk of opioid overdose.

Works with Washington State-based organizations that can distribute naloxone to the people most likely to experience or respond to an overdose: people who use drugs and their friends and family. Prioritizes applications from organizations that do not have the ability to bill insurance, such as syringe service programs, jails, street outreach teams, etc.

The Washington State Health Care Authority's (HCA) Division of Behavioral Health and Recovery (DBHR) is partnering with the Washington State Department of Health (DOH) to provide overdose response training and distributing naloxone through syringe exchange programs, local agencies, physical health settings, and emergency services.

Activities engage professional, first responders, local and regional stakeholders, and health care providers to reduce overdose risk and deaths among people who use heroin and prescription opioids. HCA DBHR contracts with DOH to carry out the program.

Per the Naloxone Distribution Plan, DOH has taken the lead on naloxone distribution and overdose response training.

This program is one of the strategies developed by the State Opioid Overdose Response Plan under the authority of Executive Order 16-109 with the purpose of preventing opioid overdose and deaths from opioid overdose, and building local infrastructure to plan, implement, evaluate, and fund overdose prevention efforts in the long-term.

The objectives are:

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

### [5195: Distributing Opioid Overdose Reversal Medications](#)

Laura Meader

(2SSB 5195) Helps to increase access to Naloxone for all individuals at risk of an opioid overdose. The law requires hospital emergency departments and many certified and licensed behavioral health settings to distribute prepackaged naloxone to individuals at risk of opioid overdose.

### [Informational web page](#)

RNP: Recovery Navigator Program

Suzanne Straub

### [RNP Fact Sheet](#)

The Recovery Navigator Program (RNP) is a statewide effort, in partnership with Behavioral Health Administrative Organizations (BH-ASOs), to provide community-based outreach, intake, assessment, and connection to services. These services support individuals with substance use disorder (SUD), including individuals with co-occurring substance use disorders and mental health conditions. Before receiving funding, each BH-ASO submitted a regional recovery navigator program plan that demonstrated the ability to implement statewide program standards.

The RNP framework incorporates harm reduction and trauma-informed care principles to support the individual throughout their recovery journey. Coordination and communication between regional RNP staff, law enforcement, prosecutors, medical providers, and community partners is essential to the

success of each individual. RNP staff facilitate and coordinate connections to a broad range of community resources for youth and adults including treatment and recovery support services (RSS).

### [Uniform Program Standards](#)

#### [RCW 71.24.115](#)

LEAD: Law Enforcement Assisted Diversion

Michele Gayle

#### [RCW 71.24.589 – Law enforcement assisted diversion – pilot project](#)

[As a result of SSB5380, HCA partnered with the PDA’s National Support Bureau to expand availability of LEAD programs outside of King County. In 2020, HCA contracted with four different sites to provide, develop, and implement LEAD programs:](#)

#### [Whatcom County](#)

#### [Snohomish County](#)

#### [Mason County](#)

#### [Thurston County](#)

Mental Health Field Response Teams/Co-Responders

Keith Lewis

Trueblood Program (Mental Health Field Response): The Mental Health Field Response Grant Program (RCW 36.28A.440) provides grants to local police and sheriff’s departments to improve the interactions between the public and law enforcement. Mental health professionals assist patrol officers in the field or in an on-call capacity, they also provide training on best practices. These innovative partnerships reduce the possibility of using force and improve public safety overall. Instead of booking someone into jail, they may be connected with services or diverted to a more appropriate facility for care. The program is one of the ways your local law enforcement is working to find solutions for communities.

#### [VIDEO: Washington State Co-Responder Program](#)

FUNDING: Received 2 million GF-S ESSB 5092§215§83 “\$2,000,000 of the general fund—federal appropriation is provided solely for grants to law enforcement and other first responders to include a mental health professional on the team of personnel responding to emergencies.”

Alternative Response Teams

Liz Wolkin

Funding is provided for the Authority to support efforts by counties and cities to implement local mobile intervention response teams to provide therapeutic alternatives in the community resulting in reduced contact with first responders. These services aim to reduce the number of people with behavioral health (mental and substance use disorders) that use costly interventions such as jail, emergency rooms, and hospitals, and to reduce the utilization of calls to the Emergency Management System from individuals

who are not getting their medical needs met due to lack of self-care, community support, or connection to resources.

FUNDING: This includes \$2 million in ongoing funds for a grant to the Association of Washington Cities; \$1.6 million in onetime funding for Whatcom County for facility renovation, equipment, and an alternative transport vehicle; and \$587,000 in ongoing operational support for the Whatcom County alternative response base station. (General Fund-State).

[AJA: Arrest and Jail Alternative Program](#)

Michele Gayle

HCA holds a Memorandum of Understanding and provides contractual oversight in collaboration with the Criminal Justice Training Center (CJTC) and Washington State Association of Sheriffs and Police Chiefs (WASPC)

[Arrest and Jail Alternatives Law Enforcement grant program](#)

[RCW 36.28A.450 Grant program – therapeutic interventions for certain criminal justice system involved persons](#)

#### *COMMUNITY ASSESSMENT and TREATMENT*

[Fee-for-Service Program for American Indian/Alaska Natives](#)

[Yvonne Keller](#)

#### FACT SHEET

Clients who have active Apple Health benefits but are not enrolled in a managed care plan may qualify for fee-for-service behavioral health benefits.

This program was created in response to concerns expressed by the Washington State Tribes and the Urban Indian Health Organizations. Individuals enrolled in Washington Apple Health (Medicaid) who identify as American Indian and/or Alaska Native (AI/AN) and are exempt from requirement to enroll in a managed care organization for physical and behavioral health (substance use disorder and mental health) treatment.

Fee Schedules (list of cost-per-service that providers collect when they provide these services under the FFS plan)

[Fee-for-service SUD services fee schedule \(as of July 2022\)](#)

[Fee-for-service MH services fee schedule \(as of July 2022\)](#)

[Fee-for-service Specialized MH fee schedule \(as of July 2022\)](#)

Mental Health Assessments for Young Children

Kimberly “Kiki” Fabian; Christine Cole

## FACT SHEET

Youth Substance Use Disorder Treatment Services

*Amy Dura*

## FACT SHEET

Eligibility requirements

Services are available for youth with SUD who meet ASAM criteria for a specific level of care. Youth are assessed to determine diagnosis, medical necessity, and to recommend appropriate level of treatment.

Apple Health (Medicaid) and low-income, youth ages 13-17 who struggle with substance use are eligible for services; younger youth or transition-age youth may receive services in some levels of care if assessed as developmentally appropriate.

Priority is given to youth who are pregnant, use drugs intravenously, are referred from a higher level of care or secure withdrawal management and stabilization (SWMS) referrals, as well as at-risk/runaway youth.

The Health Care Authority (HCA) contracts with regional behavioral health administrative services organizations (BH-ASOs), and managed care organizations (MCOs) to ensure service needs are met for Medicaid-funded youth in their region. Organizations may set sliding fee scales or non-Medicaid funding to accommodate youth in greatest need so that funding is not a barrier to youth access.

A youth 13 and older may access outpatient or residential services by signing themselves into treatment, including cases of a Child in Need of Services (CHINS) petition. A youth under the age of 13 would need consent of a parent or guardian. Parents or guardians may initiate treatment for non-consenting youth through:

Family Initiated Treatment (FIT)

The Involuntary Treatment Act (ITA)

Children's Long-Term Inpatient Program

*LaRessa Fourre, Mandy Huber*

## FACT SHEET

The Children's Long-term Inpatient Program (CLIP) is the only publicly funded, long-term inpatient program for youth in Washington State where youth ages 5-17 years old may be voluntarily committed and those from 13-17 years old may be involuntarily committed. Four CLIP inpatient psychiatric facilities have a total of 94 funded beds. These facilities are:

The state psychiatric hospital for children and youth, Child Study and Treatment Center (CSTC), in Lakewood. CSTC is under the authority of the Behavioral Health Administration (BHA) within the Department of Social and Health Services (DSHS).

Contracted community-based facilities include:

- Two Rivers Landing, Yakima
- Tamarack Center, Spokane
- Pearl Youth Residence, Tacoma

WISe: Wraparound with Intensive Services

Tina Burrell

### FACT SHEET

WISe provides comprehensive behavioral health services and supports to Medicaid-eligible youth through age 20 years of age, with complex behavioral health needs. It is focused on the children in our state with the most intensive, cross-system needs. Providing behavioral health services and supports in home and community settings, crisis planning, and face-to-face crisis interventions are critical and required components of the program.

Healthy Transitions Project

Amy Dura

### FACT SHEET

The Healthy Transitions Project (HTP) is designed to improve emotional and behavioral health functioning for transition-age youth and young adults, age 16 to 25 (referred to as TAY hereafter), to increase self efficacy and maximize their potential to lead full and productive lives. The goal is to support targeted, effective services statewide through infrastructure development.

Family Initiated Treatment

*Enos A. Mbajah*

### FACT SHEET

A parent or guardian may bring their youth, to a participating outpatient behavioral health provider, evaluation and treatment (EandT) facility, inpatient facility (licensed under RCW 70.41, 70.12, or 72.23), a secure withdrawal management facility, or approved substance use disorder (SUD) treatment program and request an evaluation to determine if the youth need mental health (MH) and/or SUD treatment. The youth's consent is not required.

The health care authority (HCA) developed 3 FIT training modules for youth, parents/guardians, providers, and the community at large. Modules 1 and 2 provide background information and address what is in the law, while module 3 is focused on best practices for treatment engagement.

Fetal Alcohol Syndrome Diagnostic and Prevention Network (FAS DPN)

*Sarah Pine*

### FACT SHEET

The WA FASDPN:

Provides 100 percent of the state's interdisciplinary FASD diagnostic and treatment referral services to individuals with fetal alcohol exposure from birth to 22 years old.

Provides FAS screening and surveillance for high-risk populations.

Identifies and refers high-risk women to intervention programs.

Developed evidence based FASD screening, diagnostic, and intervention tools through its translational research program.

Provides FASD training to community professionals

Substance Use Disorder Outpatient Treatment and Residential Services

*Patricia Dean, Gayle Martinsen*

### [FACT SHEET](#)

BH-ASO: Behavioral Health Administrative Service Organizations

### [FACT SHEET](#)

BH-ASOs provide certain behavioral health services for anyone, regardless of their insurance status or income level

### [Map](#)

### [Contract](#)

Behavioral Health Agencies (BHA)

The Washington State Dept of Health (DOH) licenses and regulates inpatient and outpatient Behavioral Health Agencies that may be certified to provide mental health, substance use disorder (SUD), problem gambling disorder services, or any combination of these types of services (OTPs are considered a BHA and require additional steps for licensing and accreditation)

[BHA Directory](#) (updated December 2021)

[RCW 71.24.037 Licensed or certified behavioral health agencies and providers – minimum standards – investigations and enforcement actions – inspections](#)

Medicaid State Plan

The State Plan is the officially recognized statement describing the nature and scope of Washington State's Medicaid Program. A State Plan is required to qualify for federal funding for providing Medicaid services. Essentially, the Plan is our state's agreement that it will conform to the requirements of the Act and the official issuances of United States Department of health and Human Services (DHHS).

[Medicaid \(Title XIX\) State Plan](#)

[Medicaid Services](#) (P. 57- 84)

[State Plan Amendments \(SPAs\) by year](#) (2015-2021)

## SPA- Medications for Opioid Use Disorder

Adult Withdrawal Management Services

Gayle Martinsen

### Fact Sheet

SWMS: Secure Withdrawal Management and Stabilization

Zephyr Forest

### SWMS Fact Sheet

Evaluation & Treatment (E&T) Facilities

*Allison Wedin, Involuntary Treatment Administrator; Zephyr Forest, SWMS Coordinator*

### E&T Fact Sheet

An Evaluation and Treatment Facility (E&T) is any facility which can provide directly, or by direct arrangement with other public or private agencies, emergency evaluation and treatment, outpatient care, and timely and appropriate inpatient care to persons suffering from a mental disorder, and which is licensed or certified as such by the Department of Health. The Health Care Authority may certify single beds as temporary evaluation and treatment beds under certain circumstances.

There are 2 types of E&T Facilities:

1. Freestanding E&Ts are licensed as a Residential Treatment Facilities (RTF) and certified by Department of Health for E&T services.
2. Hospital based E&Ts are licensed as hospitals (either a community hospital or psychiatric hospital) and certified by Department of Health as E&Ts.

Involuntary Treatment / ITA

Alison Wedin

### FACT SHEET

The Involuntary Treatment Act (ITA) provides the statutory framework for civil investigation, evaluation, detention, and commitment of individuals experiencing a mental disorder or a substance use disorder whose symptoms are so acute that the individual may need to be treated on an involuntary basis in an Evaluation and Treatment facility (E&T) or Secure Withdrawal Management and Stabilization facility (SWMS). ITA governs the actions of Designated Crisis Responders (DCRs), law enforcement, health care providers, and the court process in terms of:

Conducting investigations and evaluations to determine if an individual meets criteria for emergent or non-emergent involuntary detention and treatment;



Writing petitions so that the court may order an involuntary commitment;

Testifying in court proceedings;

Monitoring compliance for individuals who have been released from commitment under a Less Restrictive Alternative order.

Long Term Civil Commitment Bed Capacity (90 or 180 days)

*Margo Miller*

[FACT SHEET](#)

Trueblood Programs

Kara Panek, Adult Behavioral Health Section Manager

Trueblood Misdemeanor Diversion

Outpatient Competency Restoration

Forensic HARPS

Forensic PATH

Forensic Peers

Intensive Outpatient and Partial Hospitalization Pilot Program

Enos A. Mbajah

[FACT SHEET](#)

During fiscal year 2021, the Health Care Authority (HCA) was tasked with implementing the Intensive outpatient and partial hospitalization (IOP/PHP) pilot program. Additional funding was provided to extend the pilot program through 2023. The overarching goal of the pilot is to gather information to determine if these benefits should be added to the state Medicaid plan.

Intensive Residential Teams – Discharge Wraparound Services

*Matt Gower*

[FACT SHEET](#)

Intensive Residential Teams (IRT) are designed to work with people being discharged or diverted from a long-term civil commitment or state hospital who have struggled to remain in their community settings such as adult family homes (AFH) or assisted living facilities. These teams provide intensive mental health care to the individual in their facility to help them transition to a lower level of care.

**The need**

The need for this new service was identified as part of a systematic review of the state hospital discharge process. An informal gap analysis was conducted with state agencies and partners. A gap in services was identified for people in the hospital slated for discharge to DSHS/ALTSA facilities. Some of these individuals require intensive support so that they can adjust to their new setting and minimize the risk of returning to an inpatient level of care or even to a state hospital.

**The teams**

IRT teams provide services 5 days a week over multiple shifts covering at least 12 hours a day. They work with individuals with a serious mental illness who live in AFHs or assisted living facilities after discharge or diversion from a state hospital. Services will be delivered in the ALTSA facility and other appropriate community settings.

Teams consist of:

A half time dedicated prescriber

A Registered Nurses (RN)

Mental Health Professionals (MHP)

Certified peer counselors

The teams provide recovery focused treatment to promote stability, safety, and help the individual transition to a lower level of care. The teams provide medication management to the clients and primary mental health services based on the individual's need. IRT teams will use cognitive behavioral therapy for psychosis (CBT-p) as part of their approach.

[PACT: Program of Assertive Community Treatment](#)  
*Matt Gower*

**[PACT Expansion FACT SHEET](#)**

PACT is an evidence-based practice which when adopted to fidelity, provides a cost effective method of service delivery to reduce hospital, emergency services, and jail utilization. PACT teams are a multidisciplinary team that serve people with severe mental illness who frequently need psychiatric care or other crisis services. PACT teams come in different sizes, but every PACT team provides care 24/7 and consist of:

- A psychiatric prescriber
- A team leader
- Registered nurses

- Master’s level mental health professionals
- Substance use disorder professional
- Vocational and housing support
- Peer supports

PACT teams bring their support to the client where they live. This includes taking medication to the client and transporting them to support their recovery and promote independence. The teams will work the individual to build skills and work to graduate to a lower level of care.

**EXPANSION**

Prior to expansion there was 15 PACT teams in Washington: 7 full teams and 8 half teams. They serve about 1250 individuals with severe mental illness across the state. The need for PACT teams was established through community feedback and by using a gross estimation method called the Cuddeback method<sup>1</sup> which estimates that .6% of the adult population with severe mental illness. The University of Washington approximated there are possibly 4,400 individuals in Washington who could benefit from PACT: a possible difference of about 3,350 from 2018a levels. Not all in this method would be appropriate or want PACT, but it confirmed the need identified in community discussions

To begin bridging this gap, the Legislature made an appropriation in the operating budget ESHB 1109, Section 215 (4) for the HCA to stand up three full and two half teams in FY 2020 and more teams planned for FY2021.

This is intended to increase the capacity to serve individuals in their community and keep them out of the state hospitals, increasing capacity to serve 700 more individuals.

Five new teams (three full and two half) were added in FY 2020. In FY 2021, 2 new full teams were added. The third and final team was identified and was being vetted. In FY2020, 1 full PACT team closed and its replacement was being vetted with the last new team and replacement team to provide services in spring 2022.

BHITF: Behavioral Health Intensive Treatment Facilities

*Matthew Gower*

**FACT SHEET**

During a systematic review of the state hospital discharges, a group of people were identified that no longer benefited from treatment but were unable to discharge due to the need for further treatment and no appropriate facility able to provide it.

To meet this need, the legislature established a new facility called Behavioral Health Intensive Treatment Facilities (BHITF). These facilities have beds for up to 16 people to live in and receive active rehabilitative treatment. A clinical staff will work to provide recovery-based treatment using evidence-based practices, independent living skills training, social skills, and community integration. These facilities will be staffed 24/7 with a clinical team to work with the individual all hours of the day if

needed. The facilities are designed to be residences for the individuals that live there. Individuals will only be discharged from the facility if they complete their treatment plan objectives and can be safely served within the community in a less-structured setting. The facility will allow for limited egress from the facility by monitoring individuals leaving the facility and providing staff when they individual presents as a risk to themselves or others.

The legislature has provided operation and capital funds to operate four facilities in the state. Selection for the capital funds for 3 facilities was announced in October through the Department of Commerce’s Behavioral Health Facilities Grant Program spring competitive process. The chosen facilities will be located in:

- Chewelah
- Renton
- Tacoma

All three facilities are still working through building permit issues to start construction. Capital funds for 2 more facilities was included in the FY22-23 capital budget.

[Integrated Managed Care \(Apple Health/Medicaid\) behavioral health coverage Service Encounter Reporting Instructions \(SERI\), published April 2022](#)

- Substance Use Service Modalities (pg. 101)
- Other Substance Use Services (pg. 122)
- Other Behavioral Health Services (pg. 132)

[RSAT: Residential Substance Abuse Treatment \(RSAT\)](#)

Grace Burkhart, Michelle Gayle

In response to the national rise in substance use and substance related violence, the Residential Substance Abuse Treatment program was created by the Violent Crime Control and Law Enforcement Act of 1994 (Public Law 103-322). The RSAT Program assists state, local and tribal governments in development and implementation of substance use disorder treatment programs in state, local, and tribal correctional and detention facilities. RSAT also has a focus on evidence based, community reintegration, providing mental, behavioral, and social health services, to reduce substance use, substance use related violence, and incarceration.

More information on the RSAT Program may be found here: [BJA RSAT Overview](#).

Currently contract with Jefferson County and Island County jails to provide SUD treatment services and transition to aftercare services.

[OTN: Opioid Treatment Networks](#)

*Megan Fowler*

**\*\*Funding expired September 29, 2022**

## FACT SHEET

The Division of Behavioral Health and Recovery (DBHR) received funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) in 2018 for the State Opioid Response (SOR) grant to develop the Opioid Treatment Network model. This was known as SOR I (year 1 and 2). DBHR was awarded an extension for SOR I to continue through September 29, 2022 specified as SOR II. SOR Opioid Treatment Networks (OTNs) The Opioid Treatment Networks (OTNs) are second generation Hub and Spoke treatment sites that serve patients with opioid use disorder (OUD).

## LOCATIONS

OTNs are positioned to provide Medication for Opioid use Disorder (MOUD) in non-traditional treatment settings. There are 15 OTNs sites located in Washington State. They are located at:

- 7 emergency departments;
- 5 jails;
- a syringe exchange;
- a shelter;
- and a fire department.

OTNs have increased access to medications for opioid use disorder across the state. The initiation sites are the contract holders and receive funding from DBHR – distribution of funding to OTNs was prioritized based on data of highest need and location of each project to best reach the populations at most risk for overdose and death. Each OTN is responsible for providing individuals with their initial induction onto MOUD. Each OTN is staffed with a medical provider, nurse care manager, care navigator and data collector to reduce barriers for individuals seeking services at their site. SOR II requires additional services, including providing Viral Hepatitis and HIV screening and referrals. In SOR II, OTN sites are allowed to use funding to treat stimulant use disorder in addition to OUD. Sites are encouraged to refer or use Contingency Management to treat stimulant use disorder.

## ELIGIBILITY

Individuals participating in the OTNs must meet the Diagnostic and Statistical Manual of Mental Disorders (DSM 5) diagnostic criteria for OUD (and/or stimulant use disorder) and meet state and federal eligibility requirements for admission.

[Opioid treatment programs \(OTP\)](#)

Jessica Blose

Provide opioid use treatment services for people enrolled in Apple Health (Medicaid)

[OTP Directory \(updated Jan 2022\)](#)

[Hub and Spoke Projects for MOUD](#)

Linda Barker, Lora Weed

**FACT SHEET**

Connects a network of community providers around a central hub that offers medications for opioid use disorder (MOUD) compound to all patients seeking services for opioid use disorder

**Hub and Spoke Directory****LOCATIONS (11):**

Cascade Medical Advantage • Whatcom, Skagit, Snohomish, Island, San Juan Counties

Rainier Internal Medicine, dba Northwest Integrated Health • Pierce, Thurston Counties

Peninsula Community Health • Jefferson, Clallam, Kitsap Counties

Valley Cities Counseling and Consultation • King County

Harborview Medical Center • King County

Lifeline Connections • Clark, Skamania, Grays Harbor, Pacific Counties

Comprehensive Health Care • Yakima and Kittitas Counties

Ideal Options • Snohomish and Skagit Counties

Multicare Rockway Clinic • Spokane County

Olympic Peninsula Health Services • Jefferson and Clallam Counties

Northeast Washington Medical Group Providence • Pend Oreille, Stevens, and Ferry Counties

MOUD Nurse Care Manager Project

*Linda Barker*

**FACT SHEET**

The objective of the Nurse Care Manager project is to increase access to medication for opioid use disorder services. Funding for this project is part of Governor Jay Inslee's Executive Order 16-09, addressing the Opioid Use Public Health Crisis.

**ELIGIBILITY**

For an individual to receive care through this project they must meet the Diagnostic and Statistical Manual of Mental Disorders (DSM 5) diagnostic criteria for opioid use disorder (OUD) and meet state and federal eligibility requirements for admission. Pregnant and intravenous drug users are priority populations for admission.

**LOCATIONS**

DBHR contracted with nine organizations to hire a Nurse Care Manager to provide care coordination for individuals with OUD and provide community outreach regarding OUD and medication for opioid use disorder:

- Olympia Medical Center, Port Angeles
- Cascade Medical Advantage, Bellingham
- Columbia River Mental Health, Vancouver
- Columbia Valley Community Health, Wenatchee
- Community Health of Central Washington, Ellensburg
- Cowlitz Tribal Health, Tukwila
- Multicare Health Systems, Puyallup
- Peninsula Community Health Service, Port Orchard
- Rainier Internal Medicine, Pierce County Jail

[Grant Support for Certified Community Behavioral Health Clinic Expansion \(CCBHC\)](#)

*Alex Stoker*

**FACT SHEET**

The CCBHC Expansion grant program must provide access to services including 24/7 crisis intervention services for individuals with serious mental illness (SMI) or substance use disorders (SUD), including opioid use disorders; children and adolescents with serious emotional disturbance (SED); and individuals with cooccurring mental and substance disorders (COD). SAMHSA expects that this program will provide comprehensive 24/7 access to community-based mental and substance use disorder services; treatment of co-occurring disorders; and physical healthcare in one single location.

The funding **MUST** be used in the following areas:

To support direct services in: (1) 24/7 Crisis Services, including 24-hour mobile crisis teams; (2) screening, assessment, and diagnosis, including risk assessment; (3) patient-centered treatment planning or similar processes, including risk assessment and crisis planning; (4) comprehensive outpatient mental health and substance use CCHBC grants November, 2021 2 treatment services that include the provision of appropriate psychotropic medications; (5) screening for HIV and Viral Hepatitis (A, B, C).

To establish cooperative relationships with judicial officials/court systems and provided Assisted Outpatient Treatment when ordered.

Establish an Advisory Work Group comprising individuals with mental and substance use disorders, and family members, to provide input and guidance to the CCBHC on implementation, services, and policies.

Develop and implement plans for sustainability to ensure delivery of services once federal funds end. Recipients should not anticipate the continued renewal of federal funding to support this effort. Recipients will be asked to report on sustainability plans.

The funding **MAY** be used in the following areas:

Up to \$25,000 per year may be used to purchase Technical Assistance. If recipients do not need these funds for TA, they may use it for other allowable activities under the grant.

Develop and implement tobacco and vaping cessation programs, activities, and/or strategies.

Conduct an analysis of barriers and facilitators to facilitate changes in services and local relationships necessary to become fully certified.

Vocational and educational counseling aimed at assisting individuals receiving treatment to be able to better integrate into their communities and live productive satisfying lives.

Partnering with local housing authority to integrate behavioral health supports into community housing.

CCBHC grant awardees (9):

- Peninsula Behavioral Health (Port Angeles, \$2M)
- Comprehensive Healthcare (Yakima, \$2M)
- Cascade Community Healthcare (Centralia, \$2M)
- Community Health Association of Spokane (Spokane, \$4M)
- Lake Whatcom Residential Treatment (Bellingham, \$1.8M)
- Columbia River Mental Health Services (Vancouver, \$4M)
- Okanogan Behavioral Healthcare (Omak, \$733k)
- Lifeline Connections (Vancouver, \$4M)
- Columbia Wellness (Longview, \$2.3M)

#### Contingency Management (CM) Project

*Amy Dura, Lora Weed, Linda Barker*

Research evidence has shown that contingency management (CM) is the most effective intervention for stimulant use disorder. Studies demonstrate that the use of CM is associated with a reduction in number of days of stimulant use, stimulant cravings, new stimulant use, and HIV risk behaviors. Stimulant use disorders not only have adverse effects on the physical and mental health of individuals, but they also cause negative impacts on society. In the absence of a pharmacological treatment that is approved by the U.S. Food and Drug Administration (FDA), practitioners rely heavily on behavioral and psychosocial interventions and practices such as CM.

CM has been implemented at sites in two projects:

**State Hub and Spokes (5 sites):** The State Hub and Spoke project completed their CM trainings in September 2021 and are currently working with WSU PRISM staff to implement their programs and engage in fidelity monitoring.

**State Opioid Response Projects (20 sites):** The SOR projects for the CM training include the SOR Hub and Spoke (6 sites) and the Opioid Treatment Networks (14 sites). The CM training start date for the SOR sites is set for early 2022



*BEHAVIORAL HEALTH SERVICES FOR INDIVIDUALS IN THE CRIMINAL LEGAL SYSTEM*

Criminal Justice Treatment Account

Michele Gayle

[Fact Sheet](#)

[RCW](#)

The purpose of this funding is to increase the provision of substance use disorder treatment and recovery support services to justice-involved individuals. These individuals present with pending criminal charges or active enrollment in a Therapeutic Court program. A report created by the Department of Social and Health Services (DSHS) Research and Data Analysis (RDA) division surveyed 27 drug courts in Washington State and saw a 61% decrease in the rate of re-offending for individuals who participated in Drug Court.<sup>3</sup> In addition, a multi-site drug court evaluation conducted by the Justice Policy Institute indicated that drug courts produce benefits of over \$6,000 for every individual they serve and return as much as \$27 for every \$1 invested.

Funding through the Criminal Justice Treatment Account (CJTA) falls under two categories:

**Therapeutic court participants**

Therapeutic Courts provide individuals the opportunity to obtain treatment services under a closely monitored diversion program in lieu of the traditional trial track of the criminal justice system. The Washington State Legislature has indicated that therapeutic courts may decrease re-offense, improve the safety of the community, and improve the life of the participant.

**Individuals with pending criminal charges**

An individual may also receive CJTA-funded services outside of a therapeutic court environment. The county, through the input of a local CJTA panel, can implement services under a local arrangement to treat legally involved individuals that are not enrolled in a therapeutic court program. These arrangements coordinate treatment services for individuals who have charges filed by a county prosecutor and meet the eligibility requirements indicated in 71.24.580.

MOUD (Medication for Opioid Use Disorder) in Jails

Rachel Meade

[Fact Sheet](#)

[RCW](#)

Although currently there are some jails offering MOUD, not all Washington state jails offer a full MOUD program. According to a recent Washington State University study, only 37% of Washington State jails

surveyed, provide MOUD to every individual identified as having an OUD. Barriers include funding, staffing, stigma, and logistics.

A full MOUD in jails program will provide incarcerated individuals the opportunity for an OUD assessment, evidence-based medication for OUD, sustained treatment throughout incarceration and connection to continue treatment upon release or transfer. Overall benefits may include, reduction in morbidity and mortality due to overdose, reduced re-offenses, reduced complications during withdrawal, improved jail staff safety, cost savings, reduced transfers to emergency departments, custodial costs, and overall improved relationships.

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

The MOUD in Jails pilot project is currently operating at the following facilities:

Facility
Clark County Sheriff
Cowlitz County Corrections
Enumclaw Jail Program - Valley Cities
Grays Harbor Public Health (Aberdeen, Hoquiam, Grays Harbor)
Issaquah
Kittitas County Jail
Nisqually Indian Tribe
Okanogan County Jail
Olympic Peninsula Community Clinic (Clallam County Jail)
Public Health Seattle King County (Seattle/Kent)
South Correctional Entity dba SCORE
Tacoma-Pierce County Health Department (Pierce)
Walla Walla County Corrections

WASPC (Ferry, Island, Stevens County Jails)

Whatcom County Sheriff's Office (Downtown Jail/Work Center)

Same Day MOUD Visits for people transitioning out of jails

*Gayle Martinsen*

The Governor's Opioid Response Bill, [SSB 5380](#), implemented several policies and programs related to the current opioid epidemic in Washington State. The Opioid Response Bill included policy to expand the use of Medications for Opioid Use Disorder (MOUD) and included funding for the purposes of ensuring continuity of care for individuals being released from jail and are on MOUD.

The Health Care Authority, (HCA) Division of Behavioral Health and Recovery (DBHR) received legislative appropriations for the purposes of ensuring same day transitional services for individuals being released from city, county, and tribal jails. The funding is to provide a same day appointment for purposes of continuing Medication for Opioid Use Disorder (MOUD) and transportation from the jail to the community medical provider. HCA Currently contracts with Kitsap County, Benton County, King County, and South Correctional Entity for the provision of transportation and an incentive payment to providers to hold appointments so that individuals releasing from jail have no disruption in access to medication-assisted treatment for opioid use disorder.

RCSP: Reentry Community Services Program

*Alexander Stoker*

### FACT SHEET

The Reentry Community Services Program (RCSP) was created in 2000 by Senate Bill 5011 with the intent to provide improved public safety and additional mental health treatment for dangerous mentally ill, developmentally disabled and chemically dependent mentally ill individuals exiting a Department of Corrections (DOC) facility. This program was previously known as Offender Reentry Community Safety Program (ORCSP) until last legislative session.

### **ELIGIBILITY**

DOC screens individuals to determine if they meet criteria. A statewide RCSP Review Committee (cochaired by DOC and DBHR RCSP administrators) makes the final determination of entry into the RCSP program and refers the individuals to the appropriate community behavioral health agency.

### *HOUSING PROGRAMS*

**DBHR Supportive Housing Team:** *Kimberly Castle, Wanda Johns, Nicole Mims, Craig Jacobson, Michael Donovan, Lisa Bennett-Perry, Scott Tankersley, Maureen Bailey*

Housing Action Plan

*Michael Donovan, Forensic HARPS Program Manager*

John Stovall who is heading up the work for WA Low Income Housing Alliance (WLIHA) on this project is planning to provide HCA with recommendations based on their findings most likely in late September, early October before completing the project.

HARPS: Housing and Recovery through Peer Services

Wanda Johns

### [HARPS Fact Sheet](#)

Trueblood Forensics HARPS: Housing and Recovery through Peer Services

As part of the Trueblood settlement, the Health Care Authority (HCA) is setting up four Forensic Housing and Recovery through Peer Services (HARPS) teams. These teams are staffed with people who have lived experience with behavioral health challenges. This staffing model helps foster engagement with people served by the Forensic HARPS team. The goal is to help participants overcome barriers, find housing and maintain housing.

### [Summary Sheet](#)

Recovery Residence Program

*Kira Schneider*

### [FACT SHEET](#)

Recovery Residences are for people in recovery from substance use disorders. It provides a home-like environment free from alcohol and illicit drug use with a focus on peer support, assistance with obtaining addiction services, and other recovery services and support.

#### **Eligibility requirements**

Adults who are newly abstinent or in recovery and want a supportive living environment. Adults participating in or completing treatment and who need supportive affordable housing. Adults who are homeless or unstably housed and want a recovery focused environment with others in recovery.

#### **Recovery residence levels**

According to the National Alliance of Recovery Residences (NARR) and Substance Abuse and Mental Health Services Administration (SAMHSA) there are four levels of Recovery Residences, ranging from a democratically, peer run home (much like an Oxford House) to a Residential Treatment Facility for people with substance use disorders. In Washington, these four levels have been divided between housing (levels 1 and 2) and treatment (levels 3 and 4). Levels 3 and 4 are licensed and certified by the Department of Health (DOH) using WACs 246-311- 1108(2) and 246-341-1112.

### [Registry of Level 1 and Level 2 recovery residences and Oxford houses](#)

Foundational Community Supports (FCS): Supported Housing

Matt Christie, FCS program administrator

[Lisa Bennett-Perry, Supported Employment and Supportive Housing Administrator](#)

## FACT SHEET

FCS is currently one of 5 initiatives developed under Washington State’s 1115 Medicaid Transformation waiver. In 2018, FCS began providing targeted supportive housing (SH) and supported employment (SE) services to Medicaid beneficiaries with behavioral health needs and other risk factors. By focusing on the social determinants of health, the program aims to promote health equity and selfsufficiency by helping participants obtain and maintain housing and employment.

These Medicaid-reimbursable services do not replace services that are currently available, and they do not pay for room and board or wages.

HCA has contracted with Amerigroup as the third party administrator (TPA) to authorize enrollments, pay claims, and manage the FCS provider network.

### **Supportive housing services**

These innovative services are demonstrating the positive health effects that safe and secure housing can provide to people in need. To qualify, individuals must be Medicaid-eligible, complete a needs assessment, and be experiencing one of the following risk factors:

- Chronic homelessness
- Dependence on costly institutional care
- Dependence on restrictive adult residential care/treatment settings
- An in-home care recipient with complex needs
- At high risk for expensive care and negative outcomes

[PATH: Projects for Assistance in Transition from Homelessness](#)

[Lisa Bennet Perry](#)

## PATH Fact Sheet

### *MORE RECOVERY SUPPORT SERVICES*

[Foundational Community Supports \(FCS\): Supported Employment](#)

[Matt Christie, FCS program administrator](#)

[Lisa Bennett-Perry, Supported Employment and Supportive Housing Administrator](#)

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HCA has contracted with Amerigroup as the third-party administrator (TPA) to authorize enrollments, pay claims, and manage the FCS provider network.

**Supported employment services**

Supported employment services help people who have physical, behavioral, or long-term health needs that make it difficult for them to find and maintain jobs. These ongoing services include individualized job coaching and training, help with employer relations, and assistance with job placement. To qualify, individuals must be Medicaid-eligible, complete a needs assessment, and be experiencing one of the following risk factors:

- Eligible for the Housing and Essential Needs (HEN) or aged, Blind, Disabled (ABD) program.
- Significant mental illness, substance use disorder (SUD), or co-occurring conditions.
- A long-term care recipient with complex needs.
- Behavioral health challenges related to vulnerable youth and young adults

Peer Bridger Program

Annie Dejka

**FACT SHEET**

Peer Bridger staff deliver peer support services to individuals in state hospitals prior to discharge and after their return to their communities. The Peer Bridger program serves those participants currently admitted to Western or Eastern State Hospital and who have had lengthy hospitalizations or a history of frequent or multiple hospitalizations. Participation in the program is voluntary. The program is funded by the Community Mental Health Services Block Grant (MHBG) funds.

Supported by [ESHB 2376](#), Sec 204.1(v)

Mental Health Peer Respite Centers

Funding is provided for five mental health peer respite centers to divert individuals from crisis services as well as a pilot program to provide mental health drop-in center services pursuant to Second Substitute House Bill 1394 (Behavioral health facilities). The HCA must conduct a survey of peer mental health programs and submit reports to the Legislature on the results of the survey and of the pilot program.

[HB 1394 – Concerning community facilities needed to ensure a continuum of care for behavioral health patients](#)

Clubhouse Services

Laura Robbins

In response to State v. Blake, HCA has started efforts to expand Clubhouse International and Peer Run organizations. The expansion will include organizations who incorporate evidence-based practice models such as Clubhouse International, Recovery Community Organizations, and Recovery Café

[Clubhouse Directory – Washington State](#)

[Recovery Café Network](#)

Substance Use Peer Support Services

[SUD Peer Services Fact Sheet](#)

Certified Peer Counseling (CPC) is an approved Medicaid service in Washington State. CPC pairs individuals in recovery with trained counselors who share their life experience to help them find hope and make progress toward recovery. Peer support services are included in both the mental health and the substance use sections of the Medicaid State Plan, which allows appropriately licensed behavioral health agencies to provide peer support services for both mental health and substance use disorders and request Medicaid reimbursement.

PPW: Pregnant and Parenting Women Services

*Sarah Pine*

[FACT SHEET](#)

Pregnant and Parenting Women (PPW) services are designed to meet the needs of pregnant and parenting women who are seeking services. PPW are a priority population for Federal Substance Abuse Block Grant funding. PPW provides:

- SUD outpatient treatment services
- SUD residential treatment services
- Housing support services
- Therapeutic intervention for children

PCAP: Parent-Child Assistance Program

*Sarah Pine*

[FACT SHEET](#)

The Parent Child Assistance Program (PCAP) is an evidence-informed program that provides intensive case management and support services to pregnant and parenting women with substance use disorders and their young children. Previous Safe Babies, Safe Moms (SBSM) sites transitioned to adopt the PCAP model beginning in July 2017. There are currently 15 PCAP sites around Washington. PCAP services include:

- Referral, support, and advocacy for substance use disorder treatment and continuing care.
- Assistance in accessing and using local resources such as family planning, safe housing, healthcare, domestic violence services, parent skills training, child welfare, childcare, transportation, and legal services.
- Linkages to health care and appropriate therapeutic interventions for children.
- Timely advocacy based on client needs.

### **ELIGIBILITY**

Individuals are eligible if they meet all three of the following criteria:

Individuals who are currently pregnant or postpartum up to 24 months. Priority shall be given to women who are pregnant and up to 12 months postpartum; referrals shall be accepted up to 24 months postpartum on a space available basis.

Individuals who self-report at risk substance use (drugs and/or alcohol) during the current or recent pregnancy.

Individuals who have not successfully accessed community resources for substance abuse treatment and long-term recovery.

### **LOCATIONS**

PCAP is available at 15 locations, now serving 20 counties:

- Clallam-Jefferson PCAP
- Kitsap PCAP,
- Thurston-Mason-Lewis PCAP,
- Grays Harbor-Pacific PCAP,
- Cowlitz PCAP,
- Clark PCAP,
- Pierce PCAP,
- King PCAP,
- Snohomish PCAP,
- Skagit PCAP,
- Whatcom PCAP,
- Chelan PCAP,
- Yakima PCAP,
- Benton-Franklin PCAP,
- Spokane PCAP



## MANAGEMENT

Addictions, Drug and Alcohol Institute (ADAI) at the University of Washington provides quality assurance, implementation fidelity, training, and evaluation of all PCAP sites around the state. Division of Behavioral Health and Recovery (DBHR) program manager conducts contract reviews biennially.

Parent Trust: Parenting Education for Families in Recovery  
*Sarah Pine*

## FACT SHEET

Parent Trust Families in Recovery provides research based parenting education and family support services for families in residential and outpatient substance use disorder treatment centers around Washington. The overall goal is to strengthen bonding and parenting skills in families at high-risk for child abuse and neglect/Adverse Childhood Experiences (ACEs).

Parents receive training and support to:

Increase parent-child bonding

Increase positive family management skills

Increase the family's drug-free social support network

Increase child safety

Use our ACE Prevention Curriculum to decrease the number of Adverse Childhood Experiences (ACEs) parents pass on to their children.

Support and educate parents on stress management and parenting skills during a pandemic.

Support parents and their children with online schooling during the pandemic.

## ELIGIBILITY

Individuals that are pregnant or parenting and experiencing a substance use disorder.

High-risk for permanently losing custody of their children.

## LOCATIONS

Parent Trust educational programs are currently available (as of Nov 2021) at the following locations:

- Catholic Charities of Central Washington
- Evergreen Recovery Centers
- Therapeutic Health Services
- Triumph Treatment Services
- New Horizons Care Center
- Partners with Families and Children
- Circle of Parents National Network

*DATA COLLECTION and COORDINATION*

Washington State Young Adult Health Survey

The Washington State Young Adult Health Survey measures marijuana and other substance use, perceptions of harm, risk factors, and consequences among young adults (18 to 25 years old) living in Washington State. Motivated by the passage of Initiative 502 in 2012, the survey began in 2014 before recreational marijuana stores opened their doors.

[FACT SHEET: Washington State Young Adult Health Survey](#)

BHDS: Behavioral Health Data System

[V5.1 Behavioral Health Supplemental Transaction Data Guide](#)

PMP: Prescription Monitoring Program - DOH

The program was created to improve patient care and to stop prescription drug misuse by collecting dispensing records for Schedule II, III, IV and V drugs, and by making the information available to medical providers and pharmacists as a patient care tool. Program rules, [WAC 246-470](#), took effect August 27, 2011. The program started data collection from all dispensers October 7, 2011.

[Informational website](#)

[RCW 70.225 Prescription Monitoring Program](#)

Data for SOORP: State Opioid and Overdose Response Plan

[Kris Shera](#)

Currently under development, will collect population health data from DOH/PMP related to:

- Patients on high dose chronic opioid therapy > 90 mg MED
- New opioid patients who become chronic users
- Chronic opioid patients with concurrent sedative use
- Days of opioids supplied to new clients

ARM: Analytics and Research Measurement Dashboard Suite

[Healthier Washington Dashboard](#)

[ARM Dashboard](#)

Recovery Asset Mapping Tool

Funding for the development of this tool is included as a SURSAC recommendation in the SURS Plan. A demo version of this tool was presented at the February SURSAC meeting.

HCA Data Strategy and Supporting Five Year Plan

[HCA 2021-2025 Data Strategy](#) (full)

[Data Strategy one-page overview](#)

*BEHAVIORAL HEALTH WORKFORCE EXPANSION*

Behavioral Health Marketing Campaign

*Steve Perry*

**FACT SHEET**

The goal the Behavioral Health Marketing Campaign is to increased awareness of behavioral health career opportunities by driving audiences to a mobilefriendly landing page with information about behavioral health career opportunities, education programs, and financial aid resources.

Landing Page: <https://www.startyourpath.org/>

YouTube 30 sec Ad: [Start your path: Explore behavioral health careers \(30 sec. video\) - YouTube](#)

Behavioral Health Workforce Pilot Programs (ESSHB 1504)

*Steve Perry*

**FACT SHEET**

ESSHB 1504 appropriated funds to the Health Care Authority to establish three behavioral health workforce pilot programs and a training support grants program for community Mental Health providers, including clinical social workers, licensed mental health counselors, licensed marriage and family therapists, clinical psychologist, and substance abuse treatment providers. The Health Care Authority must implement these services in partnership with or through the regional accountable communities of health or the University of Washington behavioral health institute.

Proviso 40: Criminal Background Check

*Steve Perry*

**FACT SHEET**

The goal of the Proviso 40: Criminal Background task force is to reduce barriers in developing and retaining a robust Behavioral Health workforce while maintain patient safety measures.

Proviso 74: Teaching Clinic Enhancement Rates

*Steve Perry*

### FACT SHEET

Community behavioral health agencies routinely experience turnover rates of between thirty and fifty percent while average vacancy rates run three to five months to fill clinical positions. The goal of Proviso 74 is to develop a funding mechanism that recognizes and compensates community behavioral health agencies for performing a significant training function required for behavioral health workers to obtain their educational degree and clinical licensure. A service that benefits the entire behavioral health system.

Community mental health and substance use disorder treatment agencies often serve as training sites for professionals seeking supervision hours to meet licensure requirements, but stakeholders consistently report that the true costs incurred in this arrangement are not fully reimbursed, and may be a net drain on these already lean community organizations. Too often, clinicians leave for better paying jobs with lower acuity patients after completing their facility-sponsored supervision requirements.

The lack of compensation for serving as a training site, combined with high staff turnover adversely impact the ability of these sites to meet the needs of individuals who need behavioral health services.

Recognizing and compensating sites for this function may help community-based agencies provide more training opportunities, and may also lead to better retention. Providing compensation for this role would partially address reductions in standard clinical productivity as a result of time spent supervising new workers, enabling better absorption of the costs of high turnover.

### *COMMUNITY-DRIVEN SYSTEM IMPROVEMENT*

Office of Behavioral Health Consumer Advocacy

Effective Date: July 25, 2021; Sections 15-17 take effect October 1, 2022

Authorized by [ESHB 1086](#), the Department of Commerce has established the Office of Behavioral Health Consumer Advocacy to provide behavioral health consumer advocacy services to patients, residents, and clients of behavioral health providers or facilities.

Family Youth System Partner Round Tables

*Kristen Roy, Patty King*

### FACT SHEET

Family Youth System Partner Round Tables (FYSPRTs) embrace the idea that youth and families can and should have an active role in how systems serve them. FYSPRTs are a platform for families, youth, and system partners to come together to collaborate, listen, and incorporate the voice of the community into decision making at the regional and state level.

FYSPRTs are based on the System of Care core values:

- Family and youth driven
- Community based
- Culturally and linguistically appropriate

Washington has 10 regional FYSPRTs, one statewide FYSPRT, and multiple local FYSPRTs (where applicable).

Office of Recovery Partnerships

*Dakota Steel*

### FACT SHEET

The mission of the Office of Recovery Partnerships (ORP), formerly known as the Office of Consumer Partnerships, is to ensure that service recipient's individual involvement and communication is embedded in behavioral health systems. The ORP takes an active role in representation of these individuals in internal agency activities, promoting recovery and bringing this voice to the work of the Division. The ORP Manager participates in a leadership role and is on the Management Team. The ORP also has responsibility for cultivating a recovery culture within state agencies.

Washington State Children's Behavioral Health Statewide Family Network

*Patty King, Kristen Royal*

### FACT SHEET

Through a contract with [WSCC](#), the Washington State Children's Behavioral Health Statewide Family Network provides:

- Four workgroups to identify system trends related to children's outpatient behavioral health services, inpatient behavioral health services, peer support and family leader opportunities and cross-system services. These workgroups meet monthly.
- Four committees to continue the network's infrastructure development which includes committees focused on equity, diversity and inclusion, social marketing and communication, advocacy and leadership training and board of directors' capacity and advisory committee
- A webinar every other month for the purpose of workgroup and committee updates and to receive feedback on their work. The webinar can be attended by anyone interested.

- A webinar every other month in an open forum discussion format intended to engage family leaders who do not participate in committees and workgroups but can also include those who do.
- Annual weekend training to support parents/caregivers across Washington State.
- Annual Children's Behavioral Health Summit
- Technical assistance to the regional Family, Youth, System Partner Round Tables to enhance family engagement.
- Networking for parents/caregivers.
- Leadership and other trainings that include national trainers/experts

### Statewide Youth Leadership Network

*Kristin Royal*

#### FACT SHEET

The purpose of the Statewide Youth Leadership Network (Youth Network) is to facilitate the development of working relationships, a united voice and process for youth across Washington, including youth run organizations and groups, to collaborate and partner in Washington State's system change initiatives. The Statewide Youth Leadership Network is also an integral piece to sustaining the System of Care values in Washington State and will work in collaboration with the Washington State Children's Behavioral Health Statewide Family Network (Statewide Family Network).

### *FEDERAL SUD and MH FUNDING (Block Grants)*

### Substance Abuse Prevention and Treatment Block Grant

*Janet Cornell*

#### FACT SHEET

The Substance Abuse Prevention and Treatment Block Grant (SABG) supports states in planning, implementing, and evaluating activities to prevent and treat substance abuse and/or illicit use of alcohol and other drugs. The SABG supports critical services that Medicaid or other federal and state funds do not cover, such as community prevention, recovery support services, education, training, and support for individuals seeking services and their families.

A portion of the SABG funds are utilized to train peers with substance use disorder (SUD) to become certified peer counselors and provides technical assistance to community behavioral health agencies who want to add SUD peer services. Grant funds are acquired through an application process that details how the state will spend the federal funds. Grants are awarded on an annual basis, and funding comes through the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse (CSAT) and the Center for Substance Abuse Prevention (CSAP).

MHBG: Community Mental Health Services Block Grant

*Janet Cornell*

### FACT SHEET

The Community Mental Health Block Grant (MHBG) supports states in reducing their reliance on psychiatric inpatient services and facilitates the development of effective community-based mental health services and programs. The MHBG supports critical services that Medicaid or state funds do not cover, such as homeless services, housing assistance, crisis outreach, peer-operated programs including mental health clubhouse services, help lines, and education, training, and support for individuals seeking services and their families.

This program has the following specific goals:

- To ensure access to a comprehensive system of care including employment, housing, case management, rehabilitation, dental services, and health services, as well as mental health services and supports.
- To promote participation by individuals seeking services and their families in planning and implementing services and programs, as well as in evaluating state mental health systems.
- To ensure access for underserved populations including people who are homeless, residents of rural areas, and older adults.
- To promote recovery and community integration.
- To increase accountability through uniform reporting on access, quality, and outcomes of services.

MHBG: COVID Supplemental Funding

*Janet Cornell*

### FACT SHEET

Supplemental MHBG Covid Enhancement funding was provided to prevent, prepare for, and respond to SMI and SED needs and gaps due to the on-going COVID-19 pandemic. The COVID-19 pandemic has significantly impacted people with mental illness. Public health recommendations, such as social distancing, are necessary to reduce the spread of COVID-19. However, these public health recommendations can at the same time negatively impact those with SMI/SED. The COVID-19 pandemic can increase stress, anxiety, feelings of isolation and loneliness, the use of alcohol or illicit substances, and other symptoms of underlying mental illness.

SAMHSA System of Care Expansion Grant

*Alan "Ace" Bulger, Sonya Wohletz*

### FACT SHEET

The Substance Abuse and Mental Health Administration (SAMHSA) awarded the System of Care (SOC) expansion grant in September of 2018 for the improvement of behavioral health systems in Washington that serve youth, families, and caregivers. The four-year grant is designed to work towards improving long-term behavioral health outcomes and to minimize placements in restrictive settings, such as hospitals, juvenile rehabilitation, and residential treatment. SOC funds direct services, including day support services, intensive therapeutic foster care services, respite care, and also increases the availability of school-based student support specialists.



