APPENDIX 2 RESOURCE INVENTORY AND NEEDS ASSESSMENT

THE VOICES

2006 Washington State Mental Health Resource & Needs Assessment Study

Funded by the Mental Health Transformation Grant (SAMHSA) for Washington State's Mental Health Transformation Project

Washington's Mental Health Transformation Project
Partnerships for Recovery & Resiliency

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PRELIMINARY

Still Under Review 8/2/06

NOTE: This version replaces DRAFT posted on the web and dated 7/31/06. Changes are reflected in Chapter 5 with the addition of RSN regional tables plus a related appendix with additional RSN detail.

This report contains data and results from 823 structured interviews focused on four questions:

1. *Within Washington State, what is working well to address the needs of mental health consumers?*
2. *What is NOT working, creates barriers, or fails to provide quality service and support when addressing the needs of mental health consumers?*
3. *What would a "transformed" mental health system look like?*
4. *What outcomes would indicate that the changes in mental health service systems are creating improved results for consumers?*

Those interviewed were underserved consumers, served consumers, mental health specialists, and top executives and managers from 16 different state programs which provide mental health services to some of their clients. Key findings were:

- About half the low-income people who need state-funded mental health services do not get any from the umbrella state agency. For those served, access is still a problem.
- Over half the served consumers have experienced stigma and discrimination in their daily lives because of their mental illness.
- Service choices are currently very limited.
- For over half of the adult consumers interviewed, mental health services did not help them get basic resources such as employment, work training, and safe housing.
- Too many mentally ill people are in jail where treatment options are minimal, and – once released – getting access to mental health services can be tough.
- Consumers want help from one another, and they want to advocate on their own behalf.
- Coordinating and integrating mental health services for consumers with multiple conditions and service needs is both important and difficult.
- For families of children and youth with mental health needs, little or no help other than medication is available through state-provided health care.
- Service integration for consumers with multiple chronic or acute health conditions is lacking.
- Cultural competence in service delivery still needs work.

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Electronic copies of this report, county reports, and supplemental tables can be obtained from the RDA website at: http://www1.dshs.wa.gov/rda/research. *Please request report number 3.31.*

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Executive Summary

JULY 2006

PRELIMINARY | Still Under Review

A MENTAL HEALTH RESOURCE INVENTORY AND NEEDS ASSESSMENT FOR WASHINGTON STATE

Questions and Methods

To develop the Mental Health Transformation resource inventory and needs assessment, a team of researchers which included several consumers focused on four primary questions developed by the Transformation Work Group:

1. *Within Washington State, what is working well to address the needs of mental health consumers?*
2. *What is NOT working, creates barriers, or fails to provide quality service and support when addressing the needs of mental health consumers?*
3. *What would a "transformed" mental health system look like?*
4. *What outcomes would indicate that the changes in mental health service systems are creating improved results for consumers?*

These four questions were asked as part of structured research interviews with different groups of people who might be expected to have differing perspectives and stakes in the delivery of mental health services. Other questions were added to the primary four, depending on the group's "position" in the system of mental health care and other information needed to answer SAMSHA questions. Groups interviewed were:

- **Under-served Consumers:** Face-to-face interviews with 126 consumers from groups typically underserved or unserved by the current system – youth, family, elders, veterans, homeless, Spanish-speaking, and minorities. (Chapter 3)
- **Served Mental Health Division Consumers**: Telephone interviews with 384 recent consumers served by Washington State Mental Health division. (Chapter 4)
- **Served Health Plan Consumers:** Telephone interviews with 249 recent consumers served through their Department of Social and Health Services health plans. (Chapter 4)
- **Mental Health Specialist Agencies:** 20 face-to-face and telephone interviews with the state's Mental Health Division director and key staff, the directors of each of the 14 Regional Support networks, and a focus group of mental health providers. (Chapter 5)
- **Other Transformation Work Group Agencies:** 44 face-to-face interviews with top agency executives and their key managers from 16 different agencies and programs providing state-funded human services: long-term care, children's and disability programs grouped within the Department of Social and Health Services, criminal justice agencies, agencies serving students and veterans, and agencies dealing with prevention and early intervention. (Chapter 6)

The DSHS Research and Data Analysis Division also pulled together some cross-agency data describing the fragmented provision of mental health care in Washington State, which is presented in Chapter 2. Chapter 7 summarizes the key themes from this research in the matrix form required by SAMSHA. Resources, gaps and needs organized by the President's New Freedom Commission goals are described in terms of policies, practices, training, organization, budget, consumer voice, and data.

Key Findings

Several key themes emerged in this research.

Access to Services – About half the low-income people who need state-funded mental health services do not get any mental health services from the umbrella state agency. Access is a problem even among served consumers: about one third said they sometimes, rarely, or never see their therapist when needed.

There are several barriers to state service. Some result from personal characteristics (such as limited English, homelessness, being a dependent elder or child, or being in jail or prison). But most result from legislative decisions to limit state-funded mental health services to the most severe, acute and chronic. An uninsured low-income person will not be served unless they have the "right" diagnosis and are functionally severely impaired or have just left the psychiatric hospital. An insured person may have the right diagnosis, but not be impaired enough for MHD services and therefore be limited by the state health plan benefit designs to no counseling visits or 12 a year, depending on the plan. An insured person with severe impairment from the "wrong" diagnosis will not get MHD service, and hence be limited by the state health benefit design.

This situation frustrates everyone – the consumer, the mental health specialists, and the other agencies, who must deal with the mental health problems of their clients. For the consumer:

> *"DSHS told her that she couldn't get help unless she got knocked up or was really psycho."*
>
> *"Insufficient access to treatment—I had to go through a lot to get in."*
>
> *"She is not receiving counseling from any mental health facility because of the difficulty she experienced attempting to enter the system"*

The mental health specialists agree:

> *"Access to care standards are extremely confusing and limiting. The system does not provide a 'door' to treatment, but a* ***maze****."*
>
> *"We have to turn people away without treatment because we cannot use money that we have saved through efficiencies.* ***It is a financial and moral disaster."***
>
> *"Access to care standards are not flexible enough to allow children in; have to 'game' the system to allow psychiatric help for children.*

Other agencies are equally direct:

> *"Why try to determine the mental health problems kids have, if there's no access to services? What's the point?"*
>
> *"Very few of our clients are served by the Mental Health Division or other agencies; most of our clients are in the "No One" box."*
>
> *"We're not obligated to provide treatment while they (adolescents) are on parole. The problem is, no one else is, either."*

Stigma and Public Knowledge – Over half the consumers interviewed by telephone have experienced stigma and discrimination in their daily lives because of their mental illness.

> *"People say derogatory things about mentally ill people all the time."*

Other agencies agree that stigma limits the opportunities for consumers:

> *"Most employers would rather hire convicted felons than mentally ill folks."*

Most groups agreed that the general public, consumer families and friends, and consumers themselves have a very difficult time gaining any accurate information about mental illness, treatment, recovery, and the services that might help with these issues. The consumers have worked to educate themselves:

> *"I used the internet on a friend's computer to look up stuff."*

"I got information from NAMI about how to integrate the mentally ill better into the community."

But they think information needs to be made available to their families, and to the general public.

"There is no education. We need to do a campaign like they do to stop smoking."

"Families need to be educated so they understand we have an illness."

Service Choice – Service choice is currently very limited. Only those consumers who are very functionally debilitated by certain types of mental illness are entitled to more than 12 counseling visits a year. They become "enrolled" with the regional support networks of the Mental Health Division, only to find that even there the required treatment modalities are slim. Agencies, regional support networks, and providers all say that the financial incentives and structure of the current system do not favor innovation or service improvement, and in fact favor hospital inpatient care.

Consumers say:

"There is no help for people like us, can't even see a doctor when we need one. All I can get is a probation counselor who tells me what to do, and what not to do."

"An excellent mental health system would have fast response, equal access, same day crisis treatment, immediate education, therapists, and overall wellness and preventive system."

"The resources are exhausted, high turnover in doctors, revolving door treatment, I never see the same doctor twice."

"We keep coming back for services at the jail because there is never any improvement in our conditions. "

"We may stabilize but we do not receive the education and treatments to keep us out of here."

The mental health specialists agree.

"The state is in the acute care business. We are over-burdened with acute inpatient care."

"In a transformed system, we would focus on managing illness, increasing housing, employment, social life of SPMI population."

"Need to reconsider the range of available services. Need to redefine funding modalities. The rehabilitative services don't mix with Medicaid criteria and the 'billable services'."

Other agencies agree also:

"GAU clients have no access, they can get prescription coverage only, but no treatment or counseling services. Providing medications without treatment is a disservice to consumers."

Jobs, School, and Housing Help– Over half of the adult consumers interviewed said that their mental health services did not help them get basic resources such as employment, work training, and safe housing. Families and youth, and the youth-serving agencies, all stated that it is extremely difficult to get state mental health services together with schools. Therefore, the services provided do not facilitate their independence and recovery.

The consumers know what they want:

"All mentally ill people should have a home … Vulnerable people should not be living on the streets or in a shelter."

"Make work programs available to the homeless."

"I would like to see more housing, jobs and competent providers."

Mental health agencies agree and some are trying to leverage local resources. It is difficult, however, and RSNs would like more help at the state level.

> *"We need to pay more attention to what people really need … stable housing and jobs ... and schooling and training."*
>
> *"Consumer employment: RSN bought coffee-making machine, trained consumer as Barista, sells coffee in mental health center. Also have a catering service and bakery Service. Other sustaining services in the works."*
>
> *"Current employment relationship with DVR … is crippling the ability to develop 'real' employment. Employment must be important enough to have state-directed programs with money and training resources behind a coordinated effort."*
>
> *"Examine or create new avenues to re-configure housing for mentally-ill persons. We are losing affordable housing rapidly. Small motels are going out-of-business. Cost of housing going up, so mentally ill inmates recently out of prison or local jails cannot find place to stay. We are trying to work with HUD—not overly successful. Need MHD to take lead state-wide on housing issues."*
>
> *"Our RSN owns a 40 transitional bed unit which provides stable housing—a major key to success of consumers. We have tenant-based rental assistance from HUD which covers 2/3 rent payments for most clients."*
>
> *"Major gap is the state hospital. The clients can't be relocated into the community, because they have reached maximum psychiatric benefit but deemed unfit for the community. Would use new monies to buy housing in the community for enhanced care unites (24/7 care—built on models in Oregon) for fire-setters, sexual predators, etc. Contract for closed units with appropriate controls—cheaper than hospital and would clear up psychiatric beds."*

Care in Jails/Prison, and Transition to Community Care – This emphasis came mainly from consumers, particularly the underserved group, and from the criminal justice agencies. All agreed that too many mentally ill people are in jail where their treatment options are minimal, and when they get out, access to treatment gets tougher.

Consumers are well aware that jails are the "other hospitals."

> *"You ought to build more hospitals and fewer jails, because lots of the guys in jail should be in a hospital instead."*
>
> *"The jail is my usual form of hospitalization."*
>
> *"I would also see CDMHPs commit jailed individuals to the hospital that are jailed for mental health reasons and shouldn't have been there in the first place."*
>
> *"I would like to be met at the door of the jail (when released) and have someone help me find a home and a part-time job."*

Criminal justice agencies say mental health care in jail is a problem, but transition into the community is a worse problem.

> *"In here (a prison mental health unit) we do a pretty good job of stabilizing people in crisis – doing suicide watches, bringing folks down from a psychotic episode – but we aren't set up to help those who are gravely disabled, who are simply unable to take care of their own needs on a daily basis."*
>
> *"It's like this: If you're mentally ill and a criminal, you're going to have a lot of trouble finding a job and a place to live well."*
>
> *"We're not obligated to provide treatment while they (adolescents) are on parole. The problem is, no one else is, either. Too often, kids leaving JRA institutions can't get into RSNs, or onto Medicaid."*

Consumer Voice and Choice - Consumers want help from one another, and they want to advocate on their own behalf and on behalf of their peers. Transformation would mean empowerment.

> *"I have not had an experience when I felt empowered."*
>
> *"More emphasis on peer counseling, consumer advocacy, people who have been through the system and understand the consumer side."*
>
> *"A system where even consumers can work together to provide mental health treatment."*
>
> *"The whole family would be the client and respected as such. The family cares for the person usually seven days a week and yet the people who supply the most care and are the most affected are invisible to the mental heath system and treated with contempt or disgust."*

Mental health specialists agree:

> *"There's a strong effort made to involve consumers at all levels. This goes all the way from individual treatment plans to making agency policy."*
>
> *"We are hiring peer-support persons, who are required to be out in the community, and looking for improvement and recovery."*
>
> *"A transformed system would be consumer focused and directed. Consumers would be less dependent in MH and rely on themselves, peers and community resources."*
>
> *"A transformed system would include a peer counselor system, and an expanded club house and peer employment at clubhouse, as well as creating employment opportunities at club house, with providers, in the community, and job-training opportunities. Would also have Need certified peer counselors (WIMIRT can train 25 persons /semester) and training opportunities at community college."*

Service Integration and Coordination – Despite the many service integration projects existing across the state, all voices said that coordinating and integrating mental health services for consumers with multiple conditions and service needs is important and difficult. Privacy and access to integrated medical records were technical barriers to coordination. The fourteen RSNs and the existence of "silos" within state and local government also impede service coordination organizationally, by having different priorities for services.

Consumers say*:*

> *"I feel that they (various services) never coordinate; one tells me one thing and another tells us something else."*
>
> *"I tell my story over and over and over and over…"*

Mental health agencies agree that transformation needs to improve integration.

> *"A transformed system would have better client relationships with CSOs. We need better tracking of client's progress through CSO eligibility maze, better handle on inpatient client eligibility—fast-tracking."*
>
> *"We need physically integrated health care. Look for pilots in the state to copy. Mental health, physical health, and DASA need to be co-located—especially in rural areas."*
>
> *"Frequency of co-occurring disorders is rising. Need to reduce boundaries between RSN and other agencies. Need training to bring up psychiatric competencies for MH/DD issues. Need to co-locate MH in other agency venues."*

Need for better coordination with alcohol and substance treatment was clear.

> *"RSNs don't want them until they detox; we can't deal with them until they're on psych meds. We need truly blended funding with co-occurring services, not just the piece-meal services we have now"*

> *"Co-occurring collaboration. Need single or blended funding. The mentality is different, for a trained co-occurring SA/MH worker."*

> *"The split between MHD and DASA is a problem. This split, in monies and policy complicates treating co-occurring clients. We need common training with substance abuse. Need monies from Federal Block grant dedicated to co-occurring population. Need staff with co-occurring training plus licensing and certification."*

Other agencies say it is hard to get MHD and the RSNs to the table:

> *"When nursing home or group home clients go into crisis, the Mental Health Division isn't as supportive or timely as it needs to be."*

> *"We end up spending a lot of money on medication and counseling to bring people up to the point they're capable of working."*

> *"The mental health system is fractured – there's a big breakdown between mental health and chemical dependency. Children's mental health is totally broken."*

> *"There are 14 RSNs, each with a different policy focus. It's impossible to plan integrated state policy this way!"*

Cultural and Linguistic Services – Consumers for whom English is a second language often say that they do not feel respected or valued.

> *"Create services for homeless Spanish-speaking individuals and families."*

> *"Have case managers who care about Spanish-speaking people."*

> *"My culture is nor respected; they (mental health staff) look frustrated because we don't understand what they say."*

The other voices did not echo this theme. It needs more attention.

Earlier Intervention and Screening – The families of children and youth with mental health needs report that – far from being screened into services early – they and their children receive little or no help other than medication from state health care. (That is, unless the children are removed from their parents due to perceived abuse and neglect issues). All agree that the state does not provide counseling or services other than medication when mental illness is first diagnosed, but rather only when a functional debilitation becomes acute and severe. This sets up consumers for many years and untold pain before recovery can begin.

Clients know these problems firsthand:

> *"I would like to see mental health care—to be screened—when we are very young. Starting in kindergarten."*

> *"I would like to see more mental health available for teenagers with depression, because they do not know how to cope with it. Help teens with problems that can bring depression. The services should be in both languages, English and Spanish."*

The mental health specialists agree:

> *"Reaching persons before they become critically ill should be a goal of a transformed system."*

> *"Individuals need early identification and screening."*

In particular, the mental health specialists want to serve children and families.

> *"We need a completely different system for treating families and children. It should include primary care, and a central system for referring kids and families to treatment managed through a medically-integrated system. We need referrals from schools and medical system. It should be built into a health care system, with a 'vestment' strategy that would include juvenile justice and the schools. The trigger for MH need would pool entitlements and have community-based treatment plans. I'd recommend 30 hours of intensive work for children, with clear provider plan for who does what—plan needs structure. Plan should be approved at local level, go up to RSN/State than back to community to trained teams. It would be comprehensive (similar to ACT) with a director of Services. We need schools at the table."*

"Prevention is needed; we would need a new Medicaid waiver to be able to provide these services. Would include family psycho-education, early childhood prevention, work with schools."

"There would be a focus on prevention and a youth and family link – there are better success rates when families work together in therapy."

Other agencies agree that earlier intervention is key to improving the system.

"We need a stronger focus on prevention – we shouldn't wait so long to offer services, the clients lose a lot when we do this.

"We see attachment disorders, conduct disorders, and depression in kids all the time. Sometimes we just don't have the resources to deal with the problems these kids have, but we can't exclude troubled kids. The Mental Health Division doesn't serve them, so we just have to do our best to build resources around the child."

Service Quality – Some clients are very interested in evidence-based practices.

"I was impressed with the trend toward evidence-based practice."

Mental health specialists are more skeptical of the evidence – and the cost.

"RSN has significant concerns about evidence-based practices. 'Evidence' is not there for rural practice nor normalized for ethnic groups."

"Establish Evidence-Based Practices with a rural fidelity, tuned to rural communities"

"Best practices/fidelity issues not addressed at present."

More robust outcome measures, tied to recovery, and available by region and by provider within region, would help to improve practice by providing incentives for change at local levels. Mental health specialists were clearest voices:

"Need to change what we are measuring as outcomes. Need employment (better measures) and some measure of recovery implementation."

"There is no consistent measurement of outcomes across the state."

"A transformed system would have clear recovery-oriented outcomes."

For this reason, as well as to assist in the evaluation of the Mental Health Transformation, the MHT included in its proposal a substantial improvement in DSHS information infrastructure: participation in the development of a system of outcomes for each consumer, drawn from existing administrative records of "real life" events of importance to recovery. Examples of such outcomes include healthy and problem births; school success and difficulty; graduation or dropout status, employment and wages; child welfare involvement; family status; marriage and divorce; functional limitations due to disability; arrests and incarcerations; use of expensive deep-end services like hospitalizations; grant income; premature death and accidental death.

It would also be desirable to extend the reach of these outcomes beyond DSHS, to include consumers from the other Transformation Work Group agencies.

Integrated Health Records – Neither the need estimates nor the outcome data above are useful for integrated clinical teamwork with clients. For that work, the data needs to be "real time, it needs to include a treatment plan, and record actions related to that plan taken by various helping professionals. In other words, it needs to be an automated health record.

RSNs, who are trying to implement case coordination, are well aware that such work would be aided by a smart card and the automated system which might go with it.

"Consumers would benefit from a card system, a smart card, used to purchase services and allow for flexibility, and does away with artificial boundaries."

"Our RSN also uses Trilogy software from SAMHSA—a web-based consumer-oriented sites. Individual families have the ability to put personal services on a secure web-site and give access to service providers."

> *"Our RSN has integrated IS system for Netsmart. Five or six other RSNs use this system now active in 13 counties—it contains electronic health record. We have this up and running with MH + SA system, and are working with other counties to get DD on line."*

The 2006 Washington State Legislature passed a bill (SHB 2573) which directed the state Health Care Authority to *"promote and increase the adoption of health information technology systems, including electronic medical records"* and to *"coordinate a strategy for the adoption of health information technology systems"*(Section 2-B). The DSHS Health and Recovery Services Administration is participating in a cross-agency task force to develop these strategies and resolve the issues with client confidentiality that arise.

Gaps in the State's Mental Health System: Six Perspectives

These Washington themes "nest" into the work of the Present's New Freedom Commission on Mental Health, which set the stage for mental health transformation by recommending six broad goals for a transformed system that would promote recovery. The table below shows those connections.

	Washington State Needs Assessment					
	Gaps by Perspectives					
Washington State Gap Areas Organized Under the President's New Freedom Commission on Mental Health Goals	UNDER-SERVED CONSUMERS	SERVED CONSUMERS	AGENCIES	MENTAL HEALTH DIVISION	RSNS	PROVIDERS
GOAL 1: Mental Health is Essential to Overall Health						
• Access to services	✓	✓	✓	✓	✓	✓
• Stigma and public knowledge	✓	✓	✓	✓	✓	
GOAL 2: Mental Health is Consumer and Family Driven						
• Service choice and quality	✓	✓	✓	✓	✓	✓
• Jobs, school, and housing help	✓	✓	✓	✓	✓	✓
• Care in jails/prison, and transition to community care	✓		✓		✓	
• Service integration and coordination	✓	✓	✓	✓	✓	✓
• Consumer voice and choice	✓		✓	✓	✓	
GOAL 3: Disparities in Mental Health Services are Eliminated						
• Access to culturally and linguistically appropriate services	✓					
GOAL 4: Early Mental Health Screening, Assessment and Referral are Common Practices						
• Early intervention and screening	✓		✓	✓	✓	✓
GOAL 5: Excellent Mental Health Care is Delivered and Research is Accelerated						
• Service quality	✓		✓	✓	✓	✓
GOAL 6: Technology is Used to Access Mental Health Care and Information						
• Integrated health records			✓		✓	✓

Chapter 1 | **Introduction and Context**

JULY 2006

PRELIMINARY | Still Under Review

MENTAL HEALTH NEEDS, RESOURCES AND GAPS

By DSHS Research and Data Analysis Division

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Washington State was one of seven states awarded a Mental Health Transformation Grant from the federal Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services (SAMHSA|CMHS) in September 2005. The grant requires the state to conduct an assessment of need, a complete inventory of the resources devoted to serving seriously mentally ill adults and seriously emotionally disturbed children and youth, and an inventory of the gaps in those resources.

This need assessment and resource inventory was prepared by a team of researchers and consumers from the state's Department of Social and Health Services (DSHS), the University of Washington, and the Washington Institute for Mental Illness and Research. It was guided throughout its work by a larger evaluation and assessment task force, which also consisted of both researchers and consumers.

Initial findings from this report were presented in June to the Transformation Work Group, to assist them in the completion of their comprehensive mental health plan for the transformation of the funding and delivery of mental health services in Washington State. This report is the final inventory. The information presented here will serve as a baseline for future evaluation and performance measurement around that comprehensive plan.

The Washington Stage

A state diverse in geography and population

Washington State is a diverse state both in geography and population. It covers 66,582 square miles in the northwest corner of the contiguous United States with a population of just over 6 million persons (6,203,788 in 2004).[1] The Cascade mountain range divides the state into two geographically distinct regions. Western Washington contains the largest metropolitan area in the central Puget Sound region (Seattle-Tacoma), and about three-quarters of the state's population. Western Washington is also home to some rich agricultural areas and most of the state's forestry and fishing. Eastern Washington contains the second largest city (Spokane), includes much of the state's agriculture, and contains more rural and remote counties.

About one Washington resident in five (22 percent in 2003) is a member of one or more ethnic or racial minorities. The Washington minority population is diverse; nationally, Census Bureau estimates show that Washington ranks among the top ten states with largest percentage of minorities in most minority categories other than

[1] All population estimates are from US Census Bureau for 2004.

African American. In 2003, Washington ranked 3rd for Native Hawaiian and Other Pacific Islander, 6th for multiracial (175,459 in 2003), 7th for Asian, 9th for American Indian and Alaska Native, and 11th for Hispanic.

Linguistic and cultural differences enrich the state's vibrancy and way of life, but those differences challenge the equitable provision of mental health services. Washington is not a state of two languages and two cultures; it is a state of many languages and cultures. In 2004, DSHS can account for 80,828 heads of households on the TANF and Medical Caseload in which the primary language spoken was other than English – 13 percent of caseload households. The 76 languages spoken, in descending order of frequency, were:

- Spanish
- Russian
- Vietnamese
- Korean
- Chinese
- Cambodian (Khmer)
- Somali
- Tagalog
- Laotian
- Arabic
- Serbo-Croation
- Punjabi
- Farsi
- Ukrainian
- Amharic
- Tigrigna
- Romanian
- Samoan
- Ilacano
- Oromo
- Hmong
- Hindi
- Japanese
- Thai
- Polish
- French
- Indonesian
- Albanian
- Fijian
- Persian
- Portuguese
- Urdu
- Finnish
- Bulgarian
- Mien
- Greek
- Hungarian
- Gujarati
- Tongan
- French Creole
- Armenian
- German
- Swahili
- Turkish
- Burmese
- Dari
- Dutch
- Trukese
- Bengali
- Hebrew
- Cebuano
- Tibetan
- Visayan
- Italian
- Haitian-Creole
- Sudanese
- Tamil
- Czech
- Norwegian
- Pashto
- Chiu Chow
- Ilongo
- Malayalam
- Marathi
- Puyallup
- Kmhmu
- Cham
- Chamorro
- Hakka
- Ibo
- Salish
- Swedish
- Bikol
- Quechua
- Shona
- Slovak

Distribution of minority populations is uneven across the state. Asians and African-Americans are primarily concentrated in the metropolitan core counties of the Puget Sound region. Hispanics and American Indians live in both urban and rural areas in roughly equal proportions. Therefore, rural-urban and racial-ethnic differences in service delivery and access to services are complexly mingled.

Within the Washington State boundaries are 27 federally recognized Tribes, each with their own reservations and tribal lands. About half of the American Indian population lives on or near those reservations. Most tribal governments provide mental health services for their members and associates living on and near the reservations. For Tribes, coordinating their services with the state and local delivery of mental health care can be complex and challenging.

Federally Recognized Tribal Lands
Indigenous to Washington State

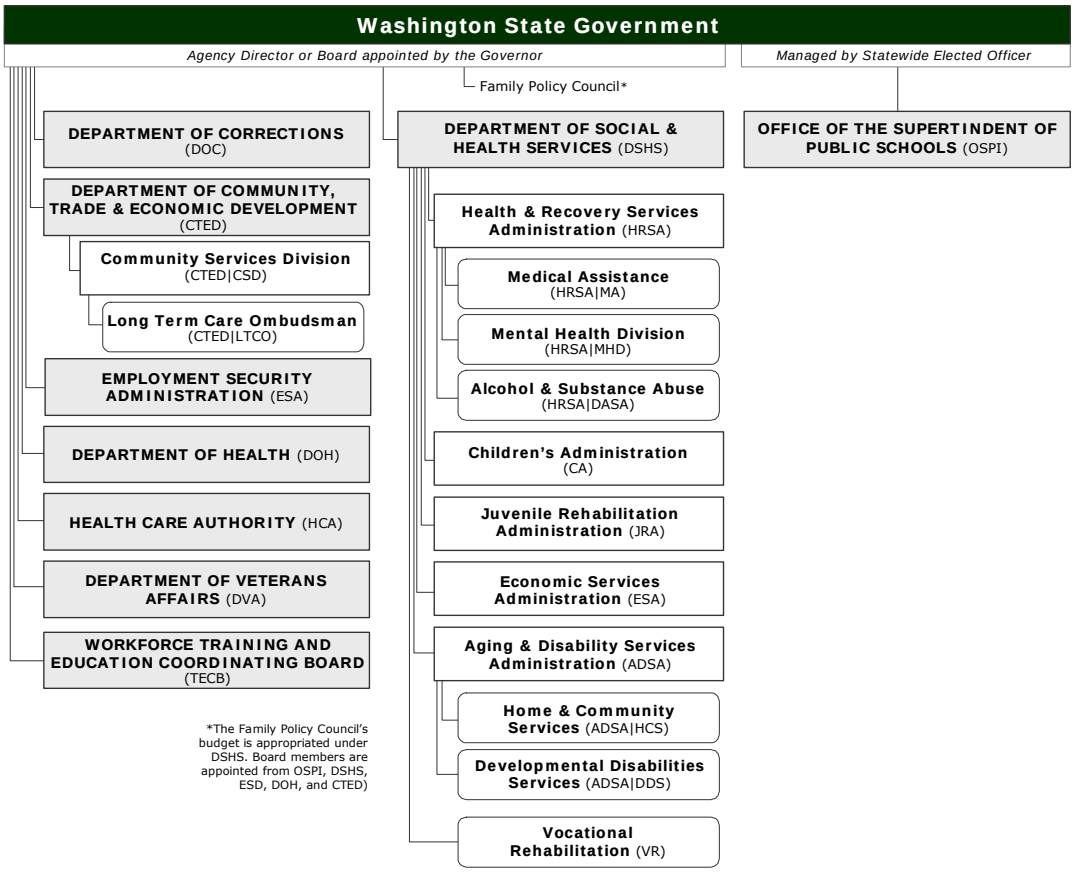
Sources: Tribal Lands – 2000 US Census Bureau and Washington State Department of Ecology. Major Highways – Washington Department of Transportation. County Boundaries - US Census Bureau 2000

Map prepared by DSHS Research and Data Analysis Division, July 2006

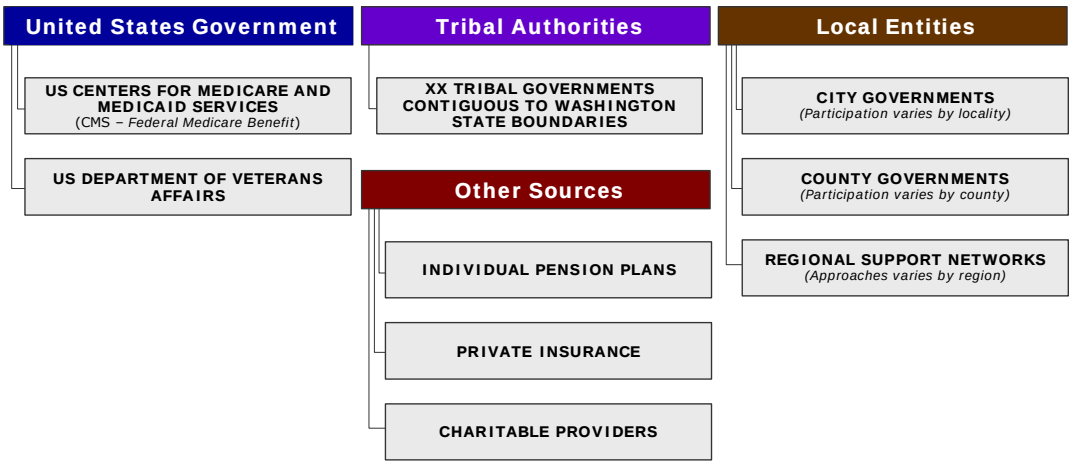
Chehalis • **Colville Council** (Colville, Chelan, Entiat, Methow, Okanogan, San Poil, Lake Nespelem, Nez Perce, Palouse, Moses, Sinkiuse, Wenatchee) • **Hoh** • **Jamestown S'Klallam** • **Kalispel** • **Lower Elwha** • **Lummi** • **Makah** • **Muckleshoot** • **Nisqually** • **Nooksack** • **Port Gamble S'Klallam** • **Port Madison Suquamish** • **Puyallup** • **Quileute** • **Quinault** • **Samish** • **Sauk-Suiattle** • **Shoalwater** • **Skokomish** • **Spokane** • **Squaxin Island** • **Stillaguamish** • **Swinomish** • **Tulalip** • **Upper Skagit** • **Yakama**

Fragmented Mental Health Service Structure

Fragmentation and specialization are the order of the day. Mental health and related recovery services are provided by 17 different state entities – some with sole mental health responsibility, and the others (such as the Department of Corrections) that provide services within the context of institutional or other programs. Most of these agencies are represented on the Transformation Work Group.



The fragmented services do not stop with state agencies. Local schools and local jails also provide services to their students and inmates, respectively. Local public health departments provide education on mental health to the public in their areas. Local communities and charities may support limited low-cost mental health services. And federal and tribal agencies provide mental health services to their low-income populations as well.



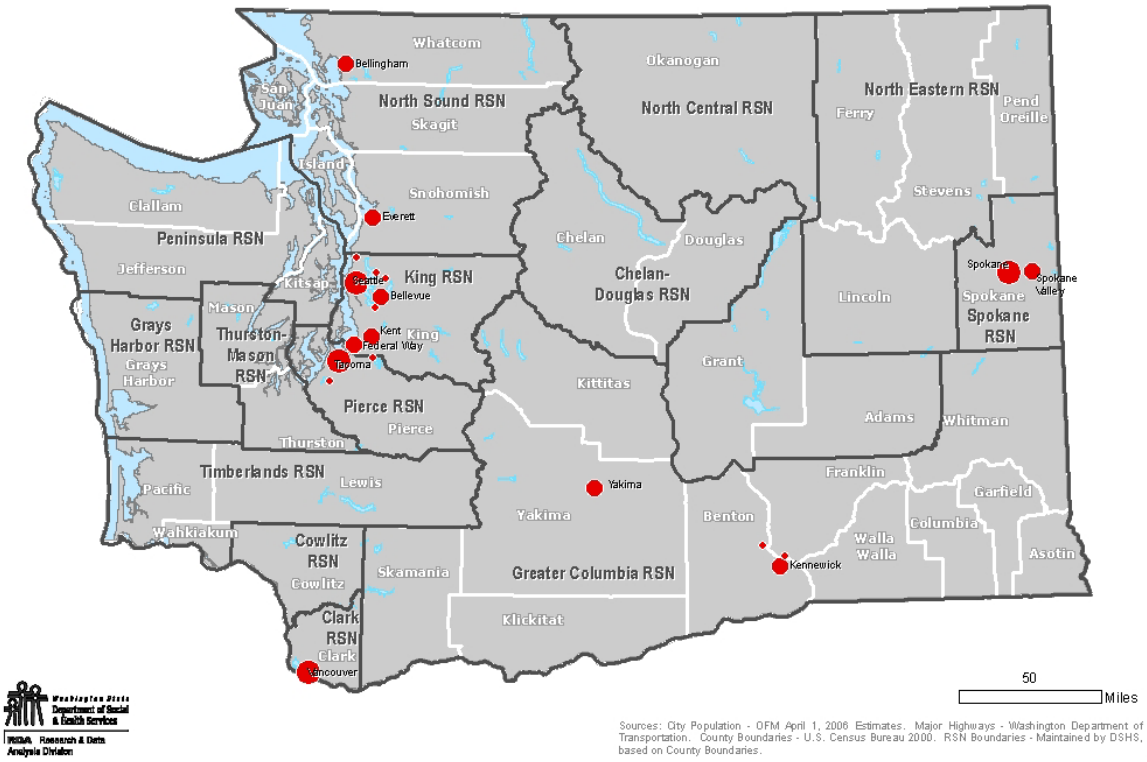
Local Government Mental Health Services

Cities, Counties, and Regional Support Networks

Three local levels of government participate in the delivery of subsidized mental health services to low-income Washington residents: cities, counties, and Regional Support Networks (RSNs). Cities in Washington State have limited taxing powers, but within those limits they can and do supplement state and federal mental health funding, particularly for mentally ill consumers in local jails and hospitals. Counties also provide some supplemental funding and often coordinate and distribute state funds. The 39 counties vary a great deal in population size and administrative capacity and complexity: the largest county (King) has almost 1.8 million people, and the smallest (Garfield) has 2,311.

The 14 Regional Support Networks (RSNs) were created by state law in 1989. They are regional administrative entities, each with an advisory and governing board and a central fiscal structure that encompasses either a single county or multiple counties. They are responsible for purchasing and managing both hospital and outpatient mental health services for any person eligible for public mental health treatment who meets their "access to care" standards. (These standards generally define the most severely, persistently and chronically mentally ill.) The state Mental Health Division contracts directly to the 14 RSNs. The RSNs then contract with providers to provide the range of mandated services, and work with community partners to coordinate that mental health care with other services mental health consumers need.

Washington State Major Cities, Counties, and RSNs



The Research Methods and Questions Asked

Key questions

Consistently, the Washington State Mental Health Transformation project focused on four primary questions in their investigation:

1. *Within Washington State, what is working well to address the needs of mental health consumers?*
2. *What is NOT working, creates barriers, or fails to provide quality service and support when addressing the needs of mental health consumers?*
3. *What would a "transformed" mental health system look like?*
4. *What outcomes would indicate that the changes in mental health service systems are creating improved results for consumers?*

Research methods underlying this report

The four primary questions were asked as part of structured research interviews with different groups of people who might be expected to have differing perspectives and stakes in the delivery of mental health services. Other questions were added to the primary four, depending on the group's "position" in the system of mental health care and other information needed to answer SAMSHA questions.

Those groups interviewed include:

- **Chapter 3. In-depth interviews with 126 consumers in key underserved groups (youth, families, elders, veterans, homeless, minorities):** A face-to-face interview protocol focused on each person's experiences with the mental health system, their view of the four questions, and their observations about the ability of the system to meet the New Freedom goals. Interviewers were trained mental health consumers. Sampling method was a snowball convenience sample.
- **Chapter 4. Random sample of 384 mental health consumers who had received services between June and November of 2005 through the state's Mental Health Division and its Regional Support Networks, from RSN-contracted providers:** The telephone survey protocol included the Recovery Oriented System Indicators (ROSI) instrument, a scale asking about experiences with stigma, general consumer satisfaction, and the four questions. Interviewers were trained mental health consumers using a computer-assisted telephone interview (CATI) system. The sample was randomly drawn from the complete list of those consumers.
- **Chapter 4. Random sample of 249 mental health consumers who had received services between June and November of 2005 through the state's health care plan, from the fee-for-service medical sector:** Same survey and interviewers as the previous set of consumers. Sample was a stratified random sample drawn from the complete list of these consumers. Stratification was by diagnosis; the sample was limited to persons whose diagnoses or medications would qualify them for services from the Mental Health Division (in other words, the sample was limited to persons with psychotic disorders, bipolar 1 and 2, and certain levels of depression and anxiety).
- **Chapter 5. Mental health providers** – A focus group was held with mental health providers who were attending a Regional Support Networks conference. The four questions were asked of the group, and their answers were explored.
- **Chapter 5. 16 in-depth interviews with regional mental health administrators** – Directors from each of the state's 14 Regional Support Networks were interviewed in 16 different interviews, to gain their perspectives, identify local issues and concerns, and assess programs they believe are going well in each of their regions. The questions asked were provided in advance of

those interviews (see Appendix C). Interviewers were DSHS staff researchers with years of experience in participant observation and interviewing.

- **Chapter 5. Four in-depth interviews with the Mental Health Division Director and key staff:** Key executives were interviewed over four sessions to gain their perspective on current services, needs, gaps and transformation issues, as well as answer fiscal, client, policy and practice questions. The questions asked were provided in advance (See Appendix D). Interviewers were DSHS staff researchers with years of experience in participant observation and interviewing.
- **Chapter 6. 44 in-depth interviews with other top agency executives and their key managers from 16 agencies/programs:** Key executives from the 16 additional Transformation Work Group agencies and programs which provide mental health services funded in the Washington State budget were interviewed at length to gain their perspective on the delivery of services today and what it would take to transform the system. Additionally, agency directors identified relevant members of their management teams who could provide added fiscal information, data, and answer significant policy questions. Interviewers and questions were the same as the MHD interviews.

In addition to the interviews, Chapter 2 contains information developed by the DSHS Research and Data Analysis Division, including estimates of the numbers needing service in Washington State and the total dollars spent on mental health services by the 17 agencies. Additional detail was provided on the number of "unduplicated" consumers served by the umbrella human service agency (DSHS), the co-occurring disorders of some of those consumers, service modalities used across the umbrella agency, and the benefit structures and lidded funding sources which defined the "supply" of services available to them.

Chapter 7. Pulls all this information together in the SAMSHA required matrix, which describes policies, practices, training, organization, budget, consumer voice, and data, plus data resources, needs and gaps under each of the "New Freedom Commission" goals.

The Report Structure

Key themes from different voices structure this report

The quantitative material summarizing data from all the agencies, and then from DSHS, is presented in Chapter 2, to provide context as to size and scope of the resources spent and persons served. Next, information from each group of stakeholders – various groups of consumers, providers, regional mental health agencies, DSHS Mental Health Division, and other agencies who provide mental health services to some consumers – is presented in the separate sections that make up the subsequent chapters of this report.

In the context of interviews and throughout our examination of the data, common themes began to emerge. These are reported within each chapter, and unique themes which surfaced in each set of interviews are also included. The common problem areas identified were:

- **Access to services** – About half the low-income people who need state-funded mental health services do not get any mental health services from the umbrella state agency, which includes the mental health, medical assistance and child protection programs within the Department of Social and Health Services (DSHS).
    1. Sometimes the person is without mental health insurance, either state or private (for example, the working poor, non-disabled adults without dependent children, persons leaving jail or prison).
    2. Sometimes the individual is still functioning, although they are suffering and their function is impaired.

3. Sometimes consumers lack the "right" diagnosis, even though they have a diagnosed mental illness and insurance to access health care that is medically necessary.
4. And some subgroups have particular problems with the system. This includes elders, people whose first language is other than English, veterans, children, youth, and families. (A few observers also mentioned rural consumers.)

Even among those who are getting mental health services, about one third said they sometimes, rarely, or never see their therapist when needed.

- **Stigma and public knowledge** – Over half the consumers interviewed have experienced stigma and discrimination in their daily lives because of their mental illness. Over half felt they were seldom, rarely, or ever supported in getting the education and guidance they and their families needed to be fully supported in their recovery.

  Every group interviewed agreed that the general public, consumer families and friends, and consumers themselves have a very difficult time gaining any accurate information about mental illness, treatment, recovery, and the services that might help with these issues.

- **Service choice and quality** – Service choice in the current system is quite limited for many people, even those who have health insurance and receive some mental health services. This is partly because only those consumers who are very functionally debilitated by certain types of mental illness are entitled to more than 12 counseling visits a year.

  Also, while some regional networks offer additional services, the required approaches to therapy – treatment modalities – are slim. Agencies, regional support networks, and providers said that the financial incentives and structure of the current system did not favor innovation or service improvement.

- **Jobs, school, and housing** – Over half of the adult consumers interviewed said that their mental health services did not help them get basic resources such as employment, work training, and safe housing. Families and youth, and the youth-serving agencies, all stated that it is extremely difficult to get state mental health services together with schools. The services provided do not facilitate independence and recovery.

- **Service integration and coordination** – All agreed that coordinating and integrating mental health services for consumers with multiple health care conditions and service needs is exceedingly difficult for the following reasons:

  1. Sheer difficulty in getting access to records
  2. The increase in privacy rules, which makes information sharing difficult
  3. The 14 relatively autonomous regions that are contracted to deliver mental health services through the state's Mental Health Division add confusion to a maze of options that is already difficult for consumer to navigate
  4. Service "silos" and their rules were also identified as a factor that limits coordination, particularly outside DSHS – these problems seem more pronounced when occurring at the local level

  We found that the consumers served often have multiple problems; we literally hear the same stories over and over and over and over.

- **Early intervention and screening –** The families of children and youth with mental health needs report that – far from being screened into services early – they and their children receive little or no help other than medication from state health care. That is, unless the children are removed from their parents due to perceived abuse and neglect issues.

  Agencies that serve schools and youth say state care is so limited there is little incentive to screen. All agree that the state does not provide counseling or services other than medication when mental illness is first diagnosed, but rather

only when a functional debilitation becomes acute and severe. This sets up consumers for many years and untold pain before recovery can begin.

These common themes "nest" into the work of the Present's New Freedom Commission on Mental Health, which in July 2003 set the stage for mental health transformation by recommending six broad goals for a transformed system that would promote recovery. This is particularly notable since the researchers did not deliberately analyze the interview contents with the new freedom goals in mind. The "similarity" in themes was arrived at independently.

Fit with the goals established by the President's New Freedom Commission on Mental Health

The President's New Freedom goals and the key common Washington themes supporting these are:[2]

	Washington State Needs Assessment					
	Gaps by Perspectives					
Washington State Gap Areas Organized Under the President's New Freedom Commission on Mental Health Goals	UNDER-SERVED CONSUMERS	SERVED CONSUMERS	AGENCIES	MENTAL HEALTH DIVISION	RSNS	PROVIDERS
GOAL 1: Mental Health is Essential to Overall Health						
• Access to services	✓	✓	✓	✓	✓	✓
• Stigma and public knowledge	✓	✓	✓	✓	✓	
GOAL 2: Mental Health is Consumer and Family Driven						
• Service choice and quality	✓	✓	✓	✓	✓	✓
• Jobs, school, and housing help	✓	✓	✓	✓	✓	✓
• Care in jails/prison, and transition to community care	✓		✓		✓	
• Service integration and coordination	✓	✓	✓	✓	✓	✓
• Consumer voice and choice	✓		✓	✓	✓	
GOAL 3: Disparities in Mental Health Services are Eliminated						
• Access to culturally and linguistically appropriate services	✓					
GOAL 4: Early Mental Health Screening, Assessment and Referral are Common Practices						
• Early intervention and screening	✓		✓	✓	✓	✓
GOAL 5: Excellent Mental Health Care is Delivered and Research is Accelerated						
• Service quality	✓		✓	✓	✓	✓
GOAL 6: Technology is Used to Access Mental Health Care and Information						
• Integrated health records			✓		✓	✓

[2] *Achieving the Promise: Transforming Mental Health Care in America*, Final Report of the President's new Freedom Commission on Mental Health, pp 5-6. July 2003.

Chapter 2 | **Data Across the System**

JULY 2006

PRELIMINARY | Still Under Review

A LOOK AT THE DATA FINDINGS ACROSS WASHINGTON STATE

By DSHS Research and Data Analysis Division

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ABSTRACT

Access: One in four Washington residents (low and high income) have a current year DSM disorder involving mood, thought, conduct, or anxiety (excludes people whose disorders are caused by dementias, organic brain injuries). 14 percent of the general population and 15 percent of the low-income population have both a disorder and associated moderate to severe limit in life function.

In FY03, Washington State spent at least $740 million dollars on mental health services for low-income populations: $500 million through the Mental Health Division and the regional networks and the rest through six other programs and agencies.

About half of the low-income state residents with DSM disorders receive some mental health services from DSHS mental health, child welfare, juvenile rehabilitation, and medical assistance. About half of the low-income state residents with associated moderate to severe limit in life function receive some services from the DSHS mental health division.

About 204,404 low-income state residents with a current year DSM diagnosis received NO mental health services from DSHS. Eligibility rules and lidded program costs make many low-income residents of Washington ineligible for DSHS or HCA funded health care coverage.

Service Choice: DSHS spent $717 million in FY03 on mental health services. About half of that went toward hospital and residential care. The rest provided prescriptions and community/other care.

This somewhat unbalanced set of expenditures is partially explained by the benefit designs for mental health care. Among those consumers who receive state-subsidized health care coverage, the "standard" adult mental health benefits include unlimited medication and medication management, one lifetime evaluation or assessment visit; 12 visits a year to a counselor; and psychiatric hospitalization as needed. The DSHS Mental Health Division (MHD) adds group therapy, brief intervention and psycho-education as needed for those consumers who are "severely, persistently, or acutely" ill and who show moderate functional impairment from their illness. If the functional impairment is severe, the MHD consumers may be offered the following modalities as medically needed: individual counseling, peer counseling, and day treatment.

Service Integration: "Deep end" consumers tend to have several different health care problems which need to be managed together. For example, by the time the working-age DSHS consumers with mental illness are on SSI and GA benefits, they frequently have multiple problems: 68 percent also have physical health conditions, 30 percent also have alcohol/drug problems, and 21 percent have both chronic physical health conditions and alcohol/drug problems.

RESEARCH METHODS

This chapter focuses on combining data across state agencies to provide some picture for the system as a whole. It uses data drawn from administrative records, estimates for rigorous national surveys, and some data drawn from the agency experts who were interviewed. These data are used to answer key questions about access to mental health services, the kinds of services used, total and by modality expenditures on mental health services, and types of service needed.

ACCESS | Service Need in the General State Population

25 percent of Washington State residents are estimated to have a DSM disorder involving mood, thought, conduct or anxiety (excludes dementias)

- 24 percent of all children and youth
- 26 percent of all working age adults
- 20 percent of all elders

14 percent of Washington State residents are estimated to have a DSM disorder involving mood, thought, conduct or anxiety and an associated limit in life function which is moderate to severe

- 8 percent of all children and youth
- 16 percent of all working age adults
- 16 percent of all elders

Statewide	Children Birth – 17	Adults 18 – 64 years	Elders 65 and older	TOTAL
Washington State residents	1,509,000	3,911,000	693,000	**6,113,000**
Washington State residents with a **DSM disorder**	356,124	1,024,682	138,600	**1,519,406**
Percent with a **DSM disorder**	23.6%	26.2%	20.0%	**24.9%**
Washington State residents with a **DSM disorder and moderate to severe limits in function**	116,193	610,116	129,730	**856,039**
Percent with a **DSM disorder and moderate to severe limits in function**	7.7%	15.6%	15.6%	**14.0%**

ACCESS | Service Need in the Low Income Population

25 percent of Washington State low-income residents are estimated to have a DSM disorder involving mood, thought, conduct or anxiety (excludes dementias)

- 24 percent of children and youth
- 26 percent of working age adults
- 20 percent of elders

15 percent of Washington State low-income residents are estimated to have a DSM disorder involving mood, thought, conduct or anxiety and an associated limit in life function which is moderate to severe

- 14 percent of children and youth
- 16 percent of working age adults
- 16 percent of elders

Low Income	Children Birth – 17	Adults 18 – 64 years	Elders 65 and older	TOTAL
Washington State residents at or below 200 percent federal poverty	553,000	955,000	235,000	**1,743,000**
Low-income Washington State residents with a **DSM disorder**	130,508	250,210	47,000	**427,718**
Percent with a **DSM disorder**	23.6%	26.2%	20.0%	**24.5%**
Low-income Washington State residents with a **DSM disorder and moderate to severe limits in function**	77,420	148,980	36,660	**263,060**
Percent with a **DSM disorder and moderate to severe limits in function**	14.0%	15.6%	15.6%	**15.0%**

THE CALCULATION

CLIENT AND POPULATION COUNTS

Total and below-200 percent-poverty populations from the March 2005 Current Population Survey.

PREVALENCE RATES

Children – Rates are drawn from Costello E J, S C Messer, H R Bird, P Cohen, H Z Reinherz 1999. "The Prevalence of Serious Emotional Disturbance: A Re-Analysis of Community Studies." *Journal of Child and Family Studies* (V7, # 4), December 1998, pp 411-432. Disorders included depression, dysthymia, social phobia, avoidant, generalized anxiety, separation anxiety, overanxious, agoraphobia, panic, simple phobia, conduct, oppositional defiant, ADD, ADHD, and alcohol or drug abuse or dependence. The "cutpoint" for impairment was the bottom 10 percent of functioning in either school, family/friends, or community.

Adults – Rates are drawn from Kessler R C, W T Chiu; O Demler; E E Waters 2005. "Prevalence, severity and comorbidity of 12-month DSM-IV Disorders in the National Comorbidity Survey Replication." *Archives of General Psychiatry* (62), June 2005, pp 617-709). Homeless persons, people in institutions, and people without telephones were not surveyed; therefore need is underestimated. DSM-4 disorders included: panic, agoraphobia, specific phobia, social phobia, generalized anxiety, post-traumatic stress, obsessive-compulsive, separation anxiety, any anxiety, major depressive, dysthymia, bipolar I and II, any mood disorder, oppositional defiant, conduct, ADD, ADHD, intermittent explosive, any impulse control, alcohol and drug abuse and dependence. Moderate to severe functional limits include suicide attempt or ideation, work disability or limitation, psychosis, bipolar 1 or 2, substance abuse or dependence, impulse control with serious violence, 30+ days "out of role" a year, and moderate role impairment in at least two areas on the Shehan scale.

Seniors – Rates are drawn from a personal communication from D Regier, W Narrow, and D Rae, reported in the *1999 Mental Health: A Report of the Surgeon General* (US DHHS), page 48. They represent a reanalysis of the ECA studies. There was no estimate of functional limitation in that study, so the adult rates were substituted. Dementias were not included in the diagnoses covered.

ACCESS | State Mental Health Expenditures in SFY2003

In FY2003, Washington State spent at least **$740 million dollars** on mental health services for low-income people.

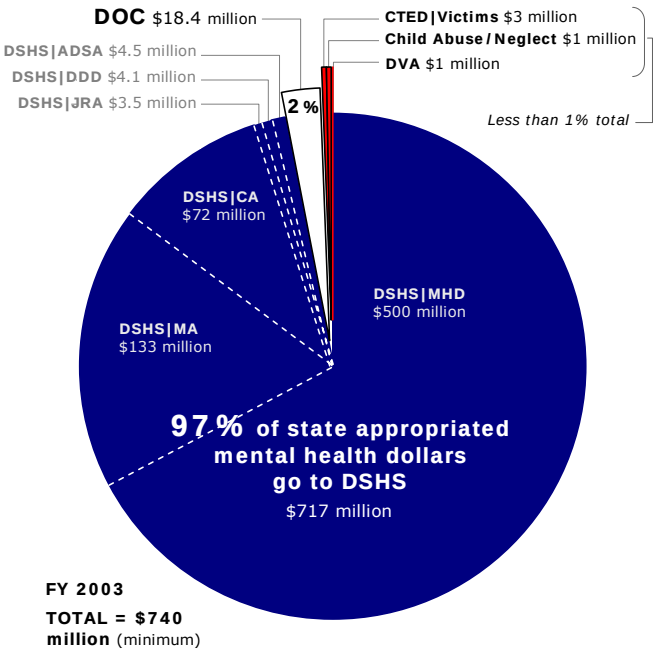
97 percent ($717 million) flowed through DSHS.

- **$500 million** through the Mental Health Division and the RSNs
- **$133 million** through health care assistance
- **$72 million** through the child welfare system to abused and neglected children and youth
- **$4.5 million** through the long-term care program to manage secure community placements outside of psychiatric hospitals for clients with dementia and behavioral problems
- **$4.1 million** through the developmental disabilities program to manage services to persons at risk of psychiatric hospitalization
- **$3.5 million** through juvenile rehabilitation to incarcerated and paroled youth

3 percent ($23 million) flowed through other state agencies.

- **$18 million** through the state Department of Corrections for services to state prison inmates.
- **$3 million** through the state Department of Community and Economic Development for services to crime victims.
- **$1 million** through the Council for the Prevention of Child Abuse and Neglect for children and families.
- **$1 million** through the state veteran's agency to veterans (Department of Veterans Affairs)

These dollars represent most but not all of total government-funded expenditures on mental health services for low-income families.



NOTE the following expenditures could not be ascertained within this time frame:

- Medications and counseling funded through the DSHS managed care Healthy Options program for adults and children who are not disabled
- Medications, counseling and psychiatric hospitalizations funded through the managed care Basic Health Plan managed by the Health Care Authority, for adults and children in working poor families
- Services funded through the DSHS Vocational Rehabilitation program
- Public school and jail counselors
- Veteran's Administration services
- Services from Tribal governments and the Indian Health Service

ACCESS | DSHS serves about half of the low-income need

Because DSHS is an umbrella agency, we can look across the programs to see how many distinct people we are serving, and compare those counts with those estimated to need care. The table below shows those calculations for most of DSHS (though it is important to note that medication management and counseling for children and adults who receive them through the Healthy Options managed care plan are not yet included in these totals).

- **At least 52 percent** of low-income state residents with DSM disorders receive some mental health services from DSHS mental health, child welfare, juvenile rehabilitation and medical assistance.
- **At least 48 percent** of state residents with a DSM mood, thought, conduct or anxiety disorder and an associated moderate to severe limit in life function receive services from the DSHS Mental Health Division.

About 204,404 low-income state residents with a current year DSM diagnosis received NO mental health services from DSHS. Some were probably served by the Basic Health Plan, jails and prisons, veterans' organizations, schools and Tribes. Some may have private insurance through their employers. Others may not have received any mental health services until they were in crisis.

Need met by DSHS	Children Birth – 17	Adults 18 – 64 years	Elders 65 and older	TOTAL
Low-income persons with a **DSM disorder and moderate-to-severe impairment**	77,420	148,980	36,660	**263,060**
Persons **getting mental health services from DSHS Mental Health Division**	36,898	79,941	10,251	**127,090**
Mental Health Division penetration rate	48%	54%	28%	**48%**
Low-income persons with a **DSM disorder**	130,508	250,210	47,000	**427,718**
Persons getting mental health services from DSHS Mental Health, Children's, Juvenile Rehabilitation and/or Medical Assistance	48,513	138,938	35,863	**223,314**
DSHS penetration rate	37%	56%	76%	**52%**

THE CALCULATION

CLIENT AND POPULATION COUNTS

State population data are for 2004 from the March 2005 Current Population Survey. MHD and DSHS counts for Fiscal Year 2003.

DSHS SERVICE ESTIMATES

Children – Includes children receiving mental health services through the DSHS Mental Health Division, Children's Administration, or the Juvenile Rehabilitation Administration. Includes children who received psychotropic medication or mental health services through fee-for-service DSHS medical coverage. Does not include children who received psychotropic medication or mental health services only through Healthy Options managed care.

Adults – Includes adults receiving mental health services through the DSHS Mental Health Division or psychotropic medications or mental health services through fee-for-service DSHS medical coverage. Does not include clients who received psychotropic medication or mental health services only through Healthy Options managed care

Seniors – Includes adults receiving mental health services through the DSHS Mental Health Division or psychotropic medications or mental health services through fee-for-service DSHS medical coverage.

SERVICE CHOICE | Types of Mental Health Services Purchased by DSHS for Working Age Adults and Elders

Adult mental health services from are heavily weighted towards residential care:

- **$33 out of every hundred dollars** is spent on psychiatric hospital stays, either in the state institutions or community hospitals.
- **$17.50 out of every hundred dollars** is spent on residential services with a strong mental health component.
- **$17.50 out of every hundred dollars** is spent on psychiatric medications.
- **$32 out of every hundred dollars** is spent on medication management, counseling, case management or other community service.

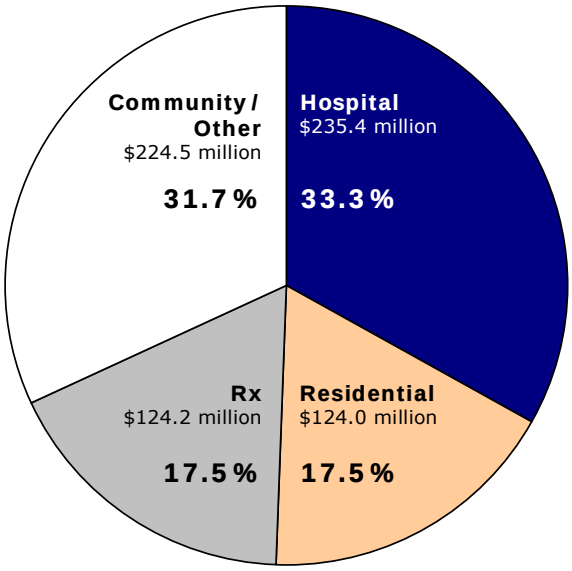
In FY 2003, DSHS spent $708 million* on fee-for-service clients for mental health services

About half went toward hospital and residential care – the rest provided prescriptions and community/other care

FY 2003

SOURCE: DSHS Division of Research and Data Analysis.

*Calculation is for fee-for-service clients only (see note below)



TOTAL = $708 million annually, minimum
(DSHS fee-for-service clients only, FY 2003)

THE CALCULATION

CALCULATIONS

Hospital – Includes MHD community psychiatric inpatient, state hospital, and child study treatment center services.

Residential – Includes MHD Residential treatment and Children's Administration Behavioral Rehabilitation Services and other intensive services including treatment foster care and group care.

Pharmacy – Includes psychotropic medications for fee-for-service clients. Excludes the cost of psychotropic medications provided through Healthy Options managed care plans, and pharmacy costs for some psychotropic medications provided in inpatient or institutional settings.

Community / Other – Includes non-residential community services funded through the MHD, non-residential mental health services funded through CA, mental health services funded through JRA, and fee-for-service non-pharmacy mental health services funded through Medical Assistance. JRA mental health service expenditures were estimated at $3.5 million. Excludes non-pharmacy mental health services funded through Healthy Options managed care plans.

SERVICE CHOICE | The DSHS Mental Health Division spends almost half its budget on psychiatric hospitalizations for less than 8 percent of its consumers

The average cost per client for inpatient stays varies by hospital type, due mostly to differing lengths of stay.

- **$7.1 million** for Child Study and Treatment Center, used by 110 children ($64,806 on average per year, per patient)
- **$171.7 million** for Eastern and Western State Hospitals, used by 3,237 adults ($53,048 on average per year, per patient)
- **$60.0 million** for community psychiatric hospitalizations, used by 8,036 people ($7,469 on average per year, per patient)

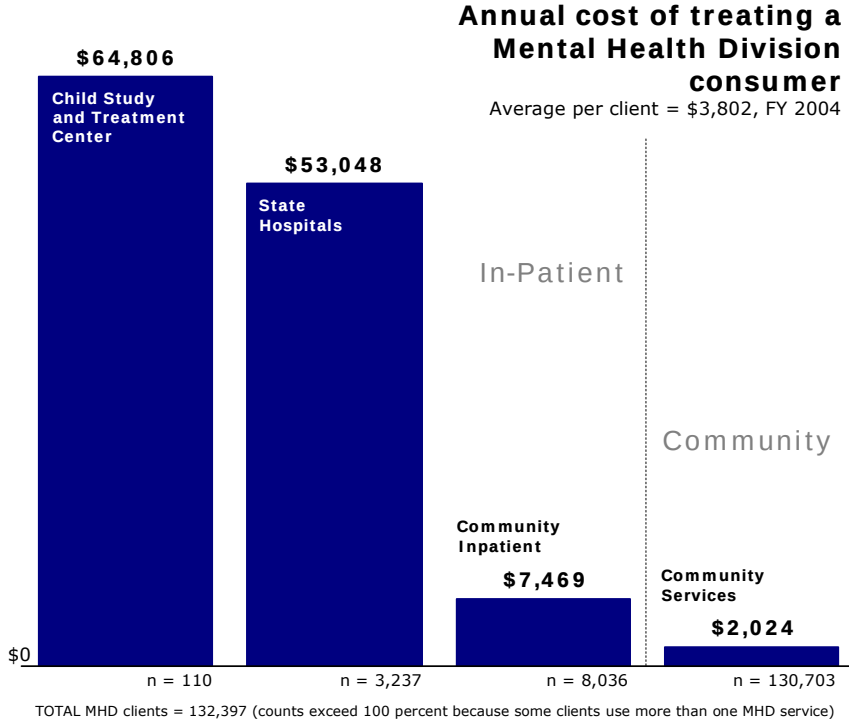
Community outpatient services include case management, medication management, group and individual treatment, psychological education for consumers and families, clubhouses, and other community-based services.

- **$264.5 million** for community services, used by 130,703 people ($2,024 on average per year, per patient)

Inpatient care is very costly and is used by very few consumers

FY 2004

SOURCE: DSHS Division of Research and Data Analysis, Client Service Database.



ACCESS | It is difficult to understand the eligibility rules for entry into state programs

The chart below shows the point of entry into state provided mental health programs can be difficult for clients and their families to find. The clients' door will depend on factors like functional limitations, type of diagnosis, income level, health care coverage, special population memberships, and available local or community funding.

Challenge One

Meeting Eligibility Standards

- **A mix of diagnosis, functionality and health plan coverage**

RSN Level 1 *DSHS Mental Health Division Entry*
Those with moderate functional impairment caused by the "right" diagnoses can receive some RSN services – but not individual therapy. Moderate functional impairment is GAF of 60 to 50 for adults, CGAS of 60 to 50 for children except those under 6

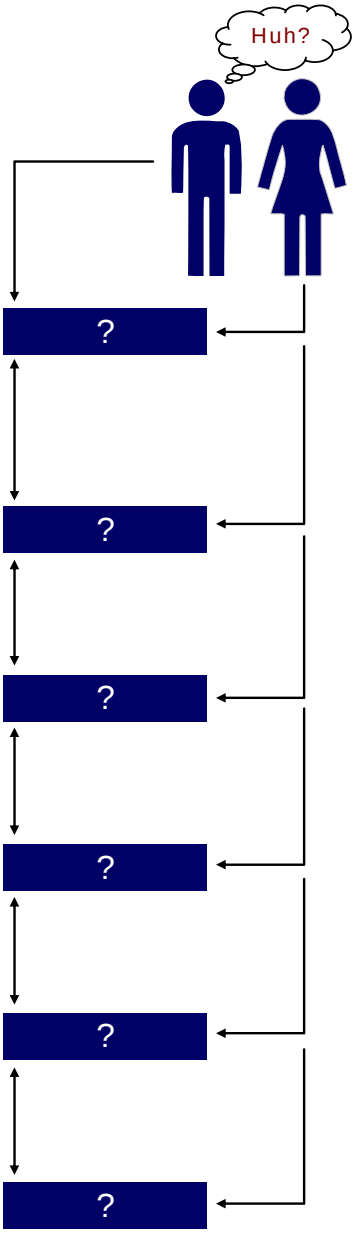
RSN Level 2 *DSHS Mental Health Division Entry*
Those with more severe functional impairment caused by the right diagnoses can receive more RSN services.
Must have a serious functional impairment means GAF of 50 or below for adults, CGAS of 50 or below for children except those under 6

Medicaid Eligible *DSHS Medical Assistance Entry*
Those on Medicaid or GA-X can receive some mental health services through their doctor
Persons on Medicaid who meet medically necessary standard of care for a DSM psychiatric diagnosis

State-Funded Plan Eligible *DSHS Medical Assistance Entry*
Those on GA-U or ADATSA receive fewer mental health services through their doctor
Persons on GA-U or ADATSA who meet medically necessary standard of care for a DSM psychiatric diagnosis

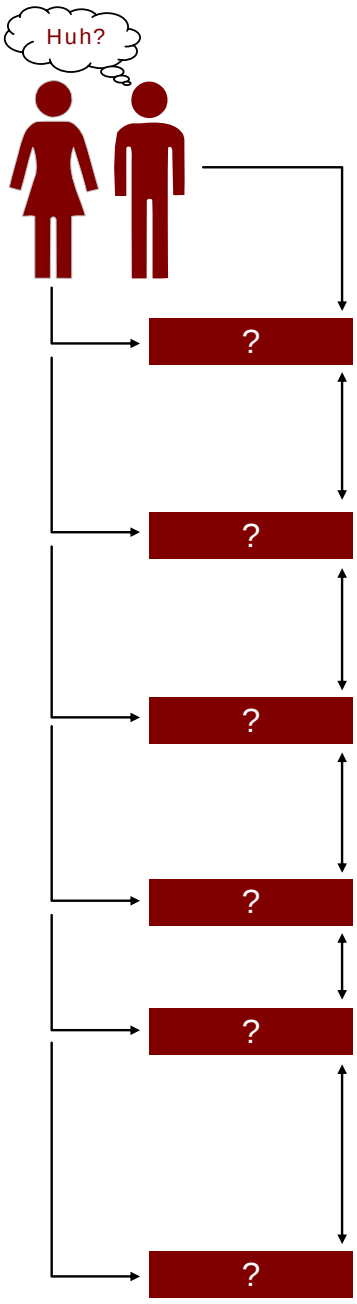
Other Medical Coverage *HCA Basic Health Plan Care Entry*
Basic Health Plan Enrollees can receive some mental health services through their doctor
Children under 19 ("Basic Health Plus" – non-TANF, non-DSHS) and Adults not eligible for free or purchased Medicaid and persons not living in state institutions where mental health care is provided

No State Provided Health Plan and does not have right diagnoses for RSN services *No state health plan services*
No health plan services – some of these people may be able to receive mental health services because they are members of special populations or have just left state mental hospitals
Abused or neglected children, inmates in state prisons or local jails prisons, veterans.



SERVICE CHOICE | Very limited counseling is available under state health plans for most consumers

The chart below shows the benefit limits for most consumers of mental health services. If they have insurance, hospitalization, medication and medication management are available, but individual counseling with a mental health professional is limited to 12 visits a year for most consumers. Most evidence-based treatments take an average of 18 to 24 visits.



Challenge Two

Getting Services Once Eligible

Once in the door, treatment options vary dramatically depending on where you live, your income, your diagnosis, your functional imitations, and your pathway to treatment

RSN Level 1 ***consumers receive the following BRIEF treatments from the RSN providers:***

- Group treatment
- Brief intervention
- Medication management
- Psycho-education
- For children, family supports

RSN Level 2 ***consumers receive the following LONGER treatments from the RSN providers – those listed above plus:***

- Individual treatment
- Medication monitoring
- Peer support

Medicaid Eligible ***clients receive the following treatments from medical providers:***

- Individual and family counseling (up to 12 visits per year)
- Unlimited medication management and monitoring
- For adults, one lifetime assessment, psychological tests and diagnostic workup
- For children, as many assessments and tests as called for in EPSDTs

State Funded Plan Eligible ***clients receive the following treatments from medical providers:***

- Unlimited medication management and monitoring
- For adults, one lifetime assessment, psychological tests and diagnostic workup
- For children, as many assessments and tests as called for in EPSDTs

Other Medical Coverage – ***Basic Health Plan enrollees receive the following treatments from medical providers:***

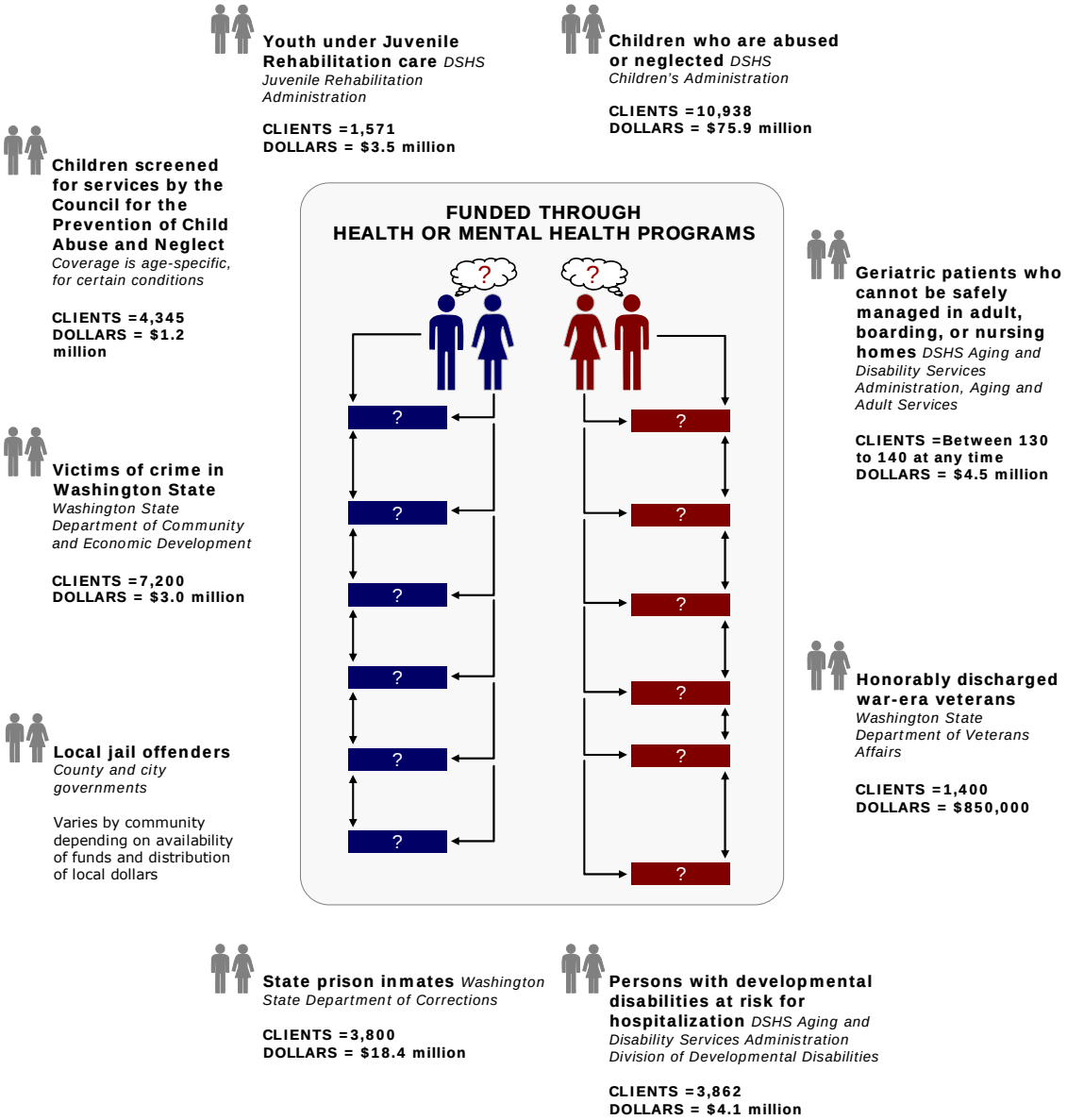
- Medication management and monitoring
- Inpatient care (up to 10 days per year)
- Individual and family counseling (up to 12 visits per year, with co-pay)

No State Provided Health Plan and does not have right diagnoses for RSN services – ***If ineligible for the above, clients go without state or federally funded services unless within a special population***

ACCESS | Other agencies and programs fund and manage some mental health services for some of their clients

Because of the access and service limitations, other social service programs provide some mental health services for some of their clients – generally for those people whose mental illness makes it difficult to "manage" them within the general program.

Mental Health Treatment Funded in Other Government Programs
IN WASHINGTON STATE



SERVICE INTEGRATION | Because consumers with functional limits often have more than one problem

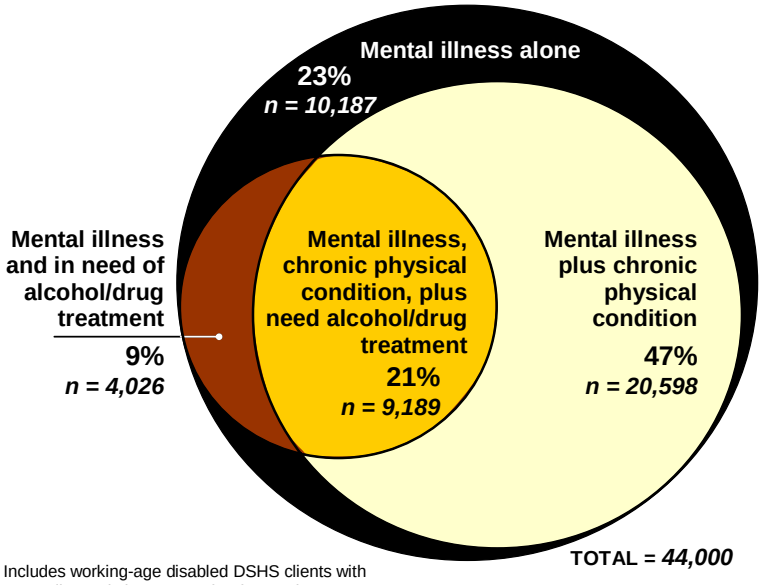
Treatment and recovery are more complicated when a person has multiple physical and mental health conditions, behavioral health issues, and family issues affecting their lives and their ability to concentrate on recovery. Such people are likely to be deeply functionally limited by their combined problems, and to find recovery more difficult. For example, among the 44,000 working age consumers with mental illness on GA or SSI:

- **68 percent** also have a chronic physical condition
- **30 percent** also have an alcohol/drug problem
- **21 percent** have BOTH a chronic physical condition and an alcohol/drug problem.

Why is service integration important?

Many consumers with mental illness have other problems

For example, three out of four of the 44,000 working-age consumers **on disability** who have mental illness also have chronic physical health problems and/or need alcohol or other drug treatment



Includes working-age disabled DSHS clients with a diagnosis in FY 2004 fee-for-service MMIS claims that **meet the Mental Health Division Access to Care Standards** minimum eligibility requirements

Chapter 3 | **Underserved Consumer Interviews**

JULY 2006

PRELIMINARY | Still Under Review

UNDERSERVED CONSUMERS SPEAK: IN-DEPTH YOUTH, FAMILY MEMBER, AND CONSUMER INTERVIEWS

By Washington Institute for Mental Illness Research and Training

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Eric J. Bruns, Ph.D.
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ABSTRACT

As one component of Washington's Needs Assessment and Resource Inventory, the Washington Institute for Mental Illness Training and Research (WIMIRT), in partnership with the University of Washington Division of Public Behavioral Health and Justice Policy (DPBHJP), completed an *In-Depth Youth, Family Member, and Consumer Interview Project*. Consumers, family members of consumers, and young people who have received support for mental health issues were trained as interviewers and interviewed total of N=126 consumers, youths, and family members. In addition to serving as a mechanism for consumers of mental health services to participate in research, the Consumer Interview Project was specifically intended to get perspectives from persons who experience mental health problems who either (1) do not access supports from the formal mental health system, or (2) were likely to be underrepresented in other data collection.

Qualitative data from interviews were analyzed by abstracting unique statements from interview records and sorting them into major themes. Results yielded common themes from across all the consumers interviewed, as well as themes about the mental health system and its transformation that were specific to certain groups. Across all interviewees, the following themes were common:

- Access to care
- Having choices
- The need for service integration and coordination
- Help with co-occurring disorders
- The presence of stigma
- Needing someone to listen

However, there were also themes that were specific to certain groups. Not surprisingly, **homeless individuals** were adamant that support for their mental health issues required assistance with jobs and housing. All 33 homeless individuals that were interviewed had an experience similar to one 35 year old African American male: A victim of child abuse, he described suffering from anxiety and post traumatic stress syndrome. Even though he's been clean and sober 8 years, he's unable to find a job or housing. He's on the waiting list for housing, which is 8 to 9 months long. He wants and needs a home and a job with coaching, he wants to be safe.

Spanish speaking individuals expressed the need for culturally relevant and language appropriate help. In one example, an eighteen-year-old Spanish-speaking female who attends high school has been severely depressed and tried to commit

suicide once. She is the daughter of migrant workers and has worked in the fields since she was 13. She was diagnosed with PTSD after being raped by two older males. She told our interviewer: "I would like to see more mental health available for teenagers with depression, because they do not know how to cope with it. Help teens with problems that can bring depression. The services should be in both languages, English and Spanish."

Youth expressed very clearly a need for help dealing with trauma and rape. One youth expressed the frustration of not being able to access help for the debilitating aftereffects of her previous sexual exploitation. Others expressed that it seemed the only way to make the system pay attention to your needs was to get pregnant or get arrested.

Family members of youth expressed a need for getting support, such as from peer professionals, and access to as much family empowerment as possible. They also frequently cited the stigma of having a child with mental health problems. Coordination of services, such as across child welfare, health, and school settings was viewed as a critical need for many family members of youth with mental health problems.

For **older adults**, it was frequently expressed that it is very important that they are treated with dignity and respect. Older adults share a common theme with youth, the desire to have someone really listen to them. In addition, the need to be able to have coordination of care across health and mental health providers was an oft-expressed need of older adults.

INTRODUCTION

From April – June, 2006, the Washington Institute for Mental Illness Training and Research (WIMIRT), in partnership with the University of Washington Division of Public Behavioral Health and Justice Policy (DPBHJP), completed an *In-Depth Youth, Family Member, and Consumer Interview Project*. This endeavor aimed to complement the collection of data via consumer phone interviews and agency administrator and Regional Support Network interviews by gaining perspectives from consumers of mental health services about the current state of the mental health system and needed improvements. The project also served as a means for Washington State's mental health transformation grant to live up to its goal of meaningful involvement of consumers in research and data collection, as all interviewers employed in the project were current and former consumers of mental health services. Family members of consumers and young people who have received support for mental health issues were also trained and participated as interviewers.

In addition to serving as a mechanism for consumers of mental health services to participate in research, the Consumer Interview Project was specifically intended to get perspectives from persons who experience mental health problems who either (1) do not access supports from the formal mental health system, or (2) were likely to be underrepresented in other data collection. The goal for data collection was to inform planning and program development and ultimately to improve the quality of mental health services delivered in the state.

Data from the interviews were presented to the Mental Health Transformation Work Group on June 16, 2006. The current report will follow the basic format of the presentation and include:

- A brief description of the methodology employed;
- Demographics of interviewees;
- Results of qualitative analysis of interviews;
- Themes and issues raised by specific demographic groups; and
- Sample representative quotes from interviewees, organized by major themes.

METHOD

Measure. Interviews consisted of two main sections. The first section included the four primary questions posed across multiple components of the NA/RI:

1. *Within the Washington State mental health service structure, what, in your opinion, is working well?*
2. *Within the Washington State mental health service structure, what, in your opinion, is NOT working, creates barriers, or fails to provide quality service and support?*
3. *From your perspective, what would a transformed mental health system look like?*
4. *What outcomes would indicate the system has transformed/changed in positive ways?*

Second, interviewees were provided with prompts to help them reflect on Washington State's current conformance to the 6 President's New Freedom Commission for Mental Health Goals:

1. Residents of Washington State understand that mental health is essential to overall health
2. Mental health care is consumer and family driven
3. Disparities in mental health services are eliminated
4. Early mental health screening, assessment, and referral to services are common practice
5. Excellent mental health care is delivered and research is accelerated
6. Technology is used to access mental health care and information

Interviewers were trained to gather information about these 10 questions in conversational format, starting with a description of the respondent's own experiences seeking help for mental health issues, and then presenting prompts to gain information about the subject matter presented above.

Procedure. Interviews were conducted by 14 consumers with ties to mental health consumer advocacy organizations, Regional Support Networks, provider organizations, clubhouses, and other entities at which consumers of mental health services can be accessed. These consumers were trained by WIMIRT staff via an all-day training, and were provided with a set of interview questions and a coding sheet on which to capture responses.

Respondents were recruited via a modified snowball sampling approach. Consumers and family members known to the interviewers and associated with their organizations were approached to complete interviews. These respondents then nominated additional consumers and family members who might be interested in completing interviews.

Interviewers were asked to focus recruitment on members of several stakeholder groups expected to be underrepresented in NA/RI activities, including:

- Young people (age 15-24)
- Family members of consumers
- Incarcerated adults and youths in juvenile justice
- Spanish-speaking individuals
- Native Americans
- Older Adults
- Homeless individuals
- Lesbian, gay, bisexual and transgender individuals
- Veterans
- African Americans
- Individuals with co-occurring disorders

Interviewees were given a $20 gift card to Safeway or Fred Meyer as an honorarium.

Data analysis. Data analysis was conducted by abstracting unique statements from respondents' interview records and sorting each statement into unique themes arranged by the major areas of interest. These areas included the four main transformation grant-planning questions presented above and the six New Freedom Goal areas.

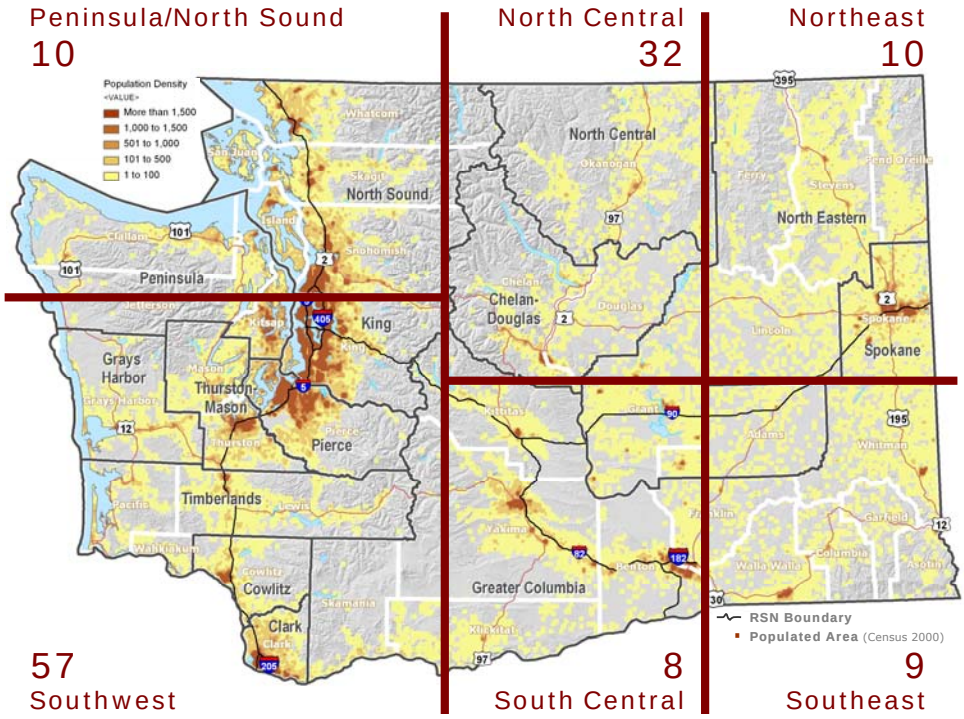
In addition, consumer leaders from WIMIRT and consumer, youth, and family member interviewers reviewed interview records to extract major themes of responses from specific demographic groups with adequate response rates to support such analyses. Such separate analyses were ultimately conducted for five special groups, including homeless individuals, Spanish speaking individuals, youths, family members of consumers, and older adults.

Results

Demographics

A total of 126 interviews were completed by the research team. The research team aimed to achieve a sample of consumers, youth, and family members that was geographically representative of the population of Washington State. This aim was fairly well achieved: Approximately 45 percent of the interviews came from residents Southwest Washington, most from the King, Pierce, and Clark County areas. (Approximately 48 percent of the population of Washington State resides in these counties.) North Central Washington, a geographic area often observed to be underrepresented in past data collection efforts, was also highly represented, with approximately 25 percent of interviews completed in Chelan and Douglas Counties. The remaining 30 percent of the interviews were completed in Northwest, Northeast, South Central, and Southeast Washington. (See map below for more complete details.)

Distribution of Interviewees Participating in the In-Depth Youth, Family Member, and Consumer Interviews



MAP SOURCES: 2003 Sub-County Population Estimates by Washington State Department of Health, Vista Partnership, Krupski Consulting: Washington State Population Estimates for Public Health. October 2004. CHART by DSHS Research and Data Analysis Division, May 2006.

Forty six percent of respondents were male and 54 percent female. With respect to the diversity of age, cultures, and ethnicities: 46 percent of respondents were Caucasian, 24 percent Latino, 14 percent Native American and 8 percent African American. Seventy percent of those interviewed fell between the ages of 26-55, while 15 percent of respondents were youths (age 15-24) and 15 percent were older adults (age >56). Efforts to target other populations perceived to be under-sampled in the NA/RI yielded a sample that included 38 percent individuals experiencing co-occurring disorders, 27 percent family members, 26 percent homeless individuals, 24 percent Spanish speaking persons, 17 percent persons involved with the criminal justice system, 14 percent Native Americans, 8 percent veterans, and 4 percent persons who self-identified as sexual minorities. (See Tables 1 and 2 below.)

Table 1.
Demographics of Respondents

GENDER	N	%
Female	68	54%
Male	58	46%

AGE	N	%
0-14	3	2%
15-24	17	13%
25-55	88	70%
56 +	18	14%

ETHNICITY	N	%
Caucasian	66	52%
Latino/Hispanic American	30	24%
Native American	18	14%
African American	10	8%
Other	2	2%

Table 2.
Other Characteristics

INSURANCE	N	%
Medicaid	48	38%
CNP	5	4%
L & I	1	1%
IHS	2	2%
Private	20	16%
Medicare	11	9%
None	39	31%

OTHER CHARACTERISTICS	N	%
Military/Veteran	10	8%
Incarcerated Adult	12	10%
Juvenile Justice	9	7%
Homeless	33	26%
Co-occurring	48	38%
Sexual Minority	5	4%
Family of child/youth	34	27%

Overall, 31 percent of consumers reported they had no health insurance, which also constituted a population of interest not able to be sampled via the consumer phone interviews component of the NA/RA. Of those that currently have insurance, approximately 55 percent use Medicaid, while only 13 percent of those with coverage utilize private insurance.

Representative Quotes from Interviewees

The diversity of opinions and voices ultimately interviewed by participants in this project makes it difficult to present overarching recommendations or needs. Given that a major goal for the project was to inject the perspectives of individuals who experience mental health issues but who are rarely approached to provide their opinions, the following section presents representative quotes that are salient to the 10 major areas of inquiry. Some of the following quotes are in the words of the respondents, while some are in the voice of the interviewers, who themselves were chosen to participate in the project because of their experiences as consumers of services provided by the mental health system.

QUESTION 1: What is working well?

- "The bright part of her life is that her therapist recognizes and has educated her regarding post traumatic stress disorder and she no longer blames herself for her depression and inability to feed or cloth herself from day to day."
- "After six months of care and much experimenting with medication, my daughter was released to our family with a prescription and a bright future ahead of her.

Her diagnosis was bi-polar II. I would estimate that the cost of her care at just under $125,000."

- "Downtown Emergency Services Center is a 12 out of 1 to 10."
- "Downtown Emergency Service Center staff really care; they would lie down on the street with you if that what they needed to do to talk with me."
- "DESC respects my culture."
- "I have a great counselor and periods of wellness and I have some financial coverage now, but not enough for all my need."
- "Eastern State Hospital is working well and the people are really nice and try to educate people about their illness."

QUESTION 2: What is not working?

- "It was a whole lot better here on the streets than any other place I had been so far."
- "She moved to her current home city so that she could be closer to her mother and have an extra pair of hands to help with her son. Unable to find work, she once again received financial assistance from welfare."
- "I just wish it would be easier to get in counseling such as if I got a referral from my doctor and I can go straight to the counseling office."
- "The judge took one look at the case and said 'What's this guy doing in jail? He should never have been in jail. The Police Department should have taken him directly to the hospital so he could be committed'."
- "Our hospital diversion is a joke, a patient can walk right out of there and MHP's don't have to let anyone know, either family or police. We had to live there in order to make sure my wife was ok."
- "We keep coming back for services at the jail because there is never any improvement in our conditions. "
- "We may stabilize but we do not receive the education and treatments to keep us out of here."
- "Families need to be educated so they understand we have an illness and they can help support us."

QUESTION 3: A transformed mental health system

- ". . . give hope to people & not make them feel like their isn't anything they can do except drink"
- "Make work programs available to the homeless."
- "Vulnerable people should not be living on the streets or in a shelter."
- "I would like to see more housing, jobs and competent providers."
- "Excellent mental health care would include being able to see a psychiatrist within a week, get started on medication regardless of cost, more safe housing that is nice."
- "The whole family would be the client and respected as such. The family cares for the person usually 7days a week and yet the people who supply the most care and are the most affected are invisible to the mental heath system and treated with contempt or disgust."
- "It is my hope that the 13.5 million dollars spent over 5 years will produce outcomes and not just a bunch of meetings that give recommendations that never happen."

- "I would like to be met at the door of the jail (when released) and have someone help me find a home and a part-time job."
- "I would like services that are family friendly and the people with these services to realize that when a person is so sick they can't function how can they expect them to understand and fill out forms and sign them."

QUESTION 4: Outcomes indicating system change

- "All mentally ill people should have a home."
- "I would also see CDMHP's commit jailed individuals from jail to the hospital that are jailed for mental health reasons and shouldn't have been there in the first place."
- "There would be good training and community awareness."
- "An excellent mental health system would have fast response, equal access, same day crisis treatment, immediate education, therapists, and overall wellness and preventive system."

GOAL 1: Stigma in Washington State

- "I fear asking for mental health because I don't want people to think I am crazy I really am not scared of asking for medicine at the doctors but I am scared of DSHS."
- "People say derogatory things about mentally ill people all the time. It never stops."
- "My ex-husband was physically abusive to our son, and he was in danger but it still took an act of God to get him back because I had been in a mental hospital for 13 days."
- "There is no education. We need to do a campaign like they do to stop smoking."

GOAL 2: Choices and Ownership in Mental Health Care

- "I have not had an experience when I felt empowered."
- "Create services for homeless Spanish speaking individuals and families."
- "Each time he has left a job, it is because of his search for better medical coverage."

GOAL 3: Accessibility of Services

- "There is no help for people like us, can't even see a doctor when we need one. All I can get is a probation counselor who tells me what to do, and what not to do"
- "She is not receiving counseling from any mental health facility because of the difficulty she experienced attempting to enter the system"
- "DSHS told her that she couldn't get help unless she got knocked up or was really psycho"
- "They had too many people on the waiting list for the week I asked for help so I got some friends to help me out by getting me my drug of choice"
- "Help for migrant workers because they work hard, pay taxes just like anybody and they do not have benefits."
- "I would like to see more mental health available for teenagers with depression, because they do not know how to cope with it. Help teens with problems that can bring depression. The services should be in both languages, English and Spanish."

- "He has given serious thought to divorcing his wife, declaring bankruptcy, gaining sole custody of his child and getting on welfare just to get his son the care and education that he knows he needs."
- "The jail is my usual form of hospitalization."
- "Maybe it's my fault, maybe I could not communicate how really bad I was. Sometimes I don't tell how bad I am because I want the medicine without being locked up."

GOAL 4: Seeking Help

- "Counselors need more time to spend with people, not be so hurried."
- "My experience is you give up so much of yourself when receiving services or help, and have so many people in your life telling you about all the things they think are wrong about you."
- "The staff is very good with me. I like being in charge of my life and taking care of myself."
- "Find people that care about people to work in the system."
- "Have case managers who care about Spanish speaking people"
- "I feel that they (various services) never coordinate; one tells me one thing and another tells us something else."

GOAL 5: Quality of Care

- "Need a place where old people will be accepted for being late, forgetful, tired, not sure, scared, lonely, needing meaningful activities."
- "Just need someone to remember I'm here even if my husband is gone."
- "My culture is not respected; they (mental health staff members) look frustrated because we don't understand what they say."
- "If I could have one thing immediately it would be a local hospital. We have to stop traumatizing the mentally ill by putting them in jail with inmate criminals."
- "I would pay the staff more money so we can have qualified people."

GOAL 6: Research and Technology

- "I was impressed with the trend toward Evidence-Based practice"
- "I receive information from NAMI and how to integrate the mentally ill better into the community."
- "I access information from NAMI Library and I like to learn about the interaction of psychiatric drugs and alcohol."
- "I used the internet on a friend's computer to look up stuff."

Results of Qualitative Analysis of Interviews

Summary of Responses to Questions about Mental Health Transformation

Table 3 presents results of a qualitative analysis of responses given by individuals interviewed regarding the current strengths, weakness, and needs for improvement of the Washington State mental health system. Overall, many of the themes remained constant throughout the questions asked of respondents. As such, responses to the

four primary Needs Assessment questions were analyzed as a whole. A summary of findings is presented below:

- The most frequently cited **helpful services** were **access to medication through mental health and non-mental health settings, drop in centers/shelters, and support groups**.
- Some individuals felt that their needs were being met, mentioning client-doctor meetings as particularly effective. However, many consumers felt that they were **unable to access necessary care**. The long processes (i.e., **"red tape"**) that it takes to get into services were mentioned as a barrier. Access to care needs improvement, especially before people are in crisis.
- **Lack of housing and financial stress on individuals and families** was discussed consistently across interviewees, suggesting a need for such basic services being provided as well as mental health treatment. Consumers cited improvement in the ability of the system to provide such basic services as an indicator that progress was being achieved in creating a transformed mental health system.
- System issues included an overall **lack of understanding of mental illness**, the tendency for individuals with mental health issues to **cycle through the legal system**, and a **lack of continuity between workers throughout the course of treatment**. Consumers recommended that all departments (i.e., DOJ, JRA, DASA) work together for the betterment of the individuals that they are serving.
- Consumers suggested that more funding be provided to offer a variety of **crisis services** (i.e., for adults, children, families, partners) which would be available 24 hours a day, 7 days a week, as well as more frequent involvement of family members in treatment.
- Populations seen as **lacking services** included **Spanish-speaking individuals, children, the working poor who may not have Medicaid, and the homeless**.
- Many people commented that they felt they were receiving **excellent care**, citing **case managers, primary care physicians, counselors**, and other organizations providing **peer support**.
- Assistance for clients **outside of typical counseling services** were also suggested, including such topics as helping with benefits, assisting with housing and employment, and help with remembering appointments.
- It was recommended that consumers be provided with more counselors who were equipped to provide better service due to a **decrease in caseloads, increase in pay, and provided with more training**. Additionally, consumers would like a greater say in the treatment they receive.
- Among the many outcomes that consumers would like to see with regard to a transformed mental health system, the most commonly mentioned issues included: a **decrease in homelessness and hospitalizations**, a **more positive spin on mental illness in the media**, **less police involvement**, **more public education**, **less wait time** for an appointment, and **financial assistance** available to everyone.
- For **youth** specifically, consumers posed several specific positive outcomes of a transformed system, including **increase in the number of young people graduating from high school and a decrease in the arrest rates of youth**.
- Outcomes for adults and families were providers working in the best interest of the family overall, rather than just the individual being treated.
- Outcomes related to **older adults** included older adults being treated with greater respect by the system and providers.

Table 3.

Results of Qualitative Analysis of Mental Health Transformation Questions

Themes	N Statements
What is Working Well?	**113**
Helpful Services	**44**
Access to medication through mental health and non-mental health settings	9
Drop in shelters	5
Support groups	4
Children's programs	3
NAMI	2
Family to Family and Peer to Peer	2
Parenting classes/support groups	2
The Behavioral Health Clinic	1
CIT for the police	1
The Promise Club	1
Kwawachee	1
The 211 service that is now available	1
Services that combine religion and psychology	1
Group homes have provided good service	1
MICA in Puyallup	1
Youth emergency services support group	1
Good Samaritan	1
Home-based community services	1
Alcoholics Anonymous	1
Crisis Line	1
CORE	1
DRA	1
Mental health services	1
Advance living skills programs	1
Who is Helping?	**40**
Primary Care Physicians	10
Case Managers	8
Counselors	7
Clubhouse	4
Peer counselors	4
Eastern State Hospital	3
Parent advocates	1
Fairfax inpatient	1
DESC	1
Caretakers assigned to DD youth	1
Positive Experiences	**15**
Feel that needs are being met	10
Doctor/client meetings are positive	4
Has more access to services now than in the past	1

Systems	**8**
The community/public health system	3
The legal system (i.e., jail and juvenile detention)	3
The mental health system	1
The RSN system (most of the time)	1
Negative Experiences	**6**
Felt that needs have not been met	5
Was mistreated by staff	1
What is Not Working?	**125**
Overall	**49**
Unable to access necessary care	16
Long processes ("red tape") to get services	6
Providers don't always care about what happens to their clients	4
Lack of safe shelters/housing	4
Financial stress on individuals and families	4
Lack of understanding of available services	4
Nothing is working well	3
Counselors cannot spend enough time with clients	1
Not enough community activities	1
Not enough options for older adults	1
Doctors blame clients for drug use	1
Unwelcoming services	1
Everything is working well	1
People don't always fit into the categories provided	1
Lack of follow through by providers	1
System Issues	**44**
Lack of understanding of mental illness	9
Lack of continuity between services and individual workers	8
Individuals cycling through the jail system	6
No access to care in rural communities	4
Youth going to jail instead of the emergency room for services	3
The RSN governing board does not govern for the good of the community	2
Lack of employment opportunities	2
No access to ongoing care (i.e., always has to use crisis services)	2
Medicaid does not provide access to a variety of services	2
Racism within the system	1
CPS called when parents try to access help	1
Not enough respite services with appropriate care	1
Funding cuts are eliminating necessary programs	1
People are cut off of SSI	1
Not enough activities to help with recovery	1
Solutions	**18**
Involve family members and friends in treatment	6
More education on mental illness	5
Need self-help and support groups	2
24 hour access to care	2

Hire more people of color at the programs	1
Provide insurance coverage to everyone	1
Provide more than just medication for treatment	1
Populations Lacking Services	**14**
Spanish-speaking individuals	6
Children	4
Homeless individuals	3
The working poor	1
Features of a Transformed Mental Health System	**152**
Specific Suggestions	**65**
Safe housing available	14
24 hour access to care	9
More services in rural towns	8
Assistance for clients outside of counseling (i.e., with benefits, remembering appointments, finding a job/housing)	5
Education around mental illness	4
Inform people of available programs	3
Counselors would have more time with clients	3
Sliding fee services	2
Evaluation of systems conducted regularly	2
Intake would take no more than 20 minutes and would be meaningful	2
Consistency of counselors throughout treatment	2
Have more doctors who focus on specific diagnoses	2
Mental health worker in every school	1
Need opportunities for education	1
Provide peer counseling services	1
Consumers occupying top mental health system positions	1
A Mega Clinic with different departments for each mental illness	1
Local detox center	1
More programs for co-occurring, life skills, etc. available	1
Culturally and linguistically appropriate services	1
Should be able to detox voluntarily	1
Service Level	**43**
Pay attention to concerns of family members and friends (esp. parents)	10
More counselors equipped to provide better services	9
Clients need to have a say in their treatment	6
Earlier recognition of symptoms	3
People would know what services are available	3
Would not have to have severe symptoms in order to receive services	3
Client would come first	2
Not having to wait for appointments	2
Provide most up to date care	1
More services for young children	1
Counseling and medication available together	1
More follow-up care	1
Better understanding of children's mental health	1

System Level	**38**
Improve access to care (spec. pre-crisis)	18
Financial ability would not be an issue in receiving treatment	6
All departments (DOJ, JRA, DASA, etc.) working for betterment of person	5
Provide good jobs for people	3
Give people treatment, rather than sending them to jail	2
Healthcare for everyone	1
Awareness in government	1
There should be no wrong door	1
School personnel need to play a bigger role	1
Personal Level	**5**
Individuals would be known for traits other than their illness	1
Children need people who will love and care for them	1
People need to believe that they can get better	1
No one would be judged as unable to treat	1
Clients need to feel useful and productive	1
Regarding the Transformation Grant	**1**
The money spent to improve the system should not be wasted on a bunch of meetings and no outcomes	1
Outcomes Indicating System Change	**86**
Generic Outcomes	**34**
Decrease in homelessness	7
Positive spin in the media	6
People would be educated with regard to mental illness	6
Mental illness is seen as "normal illness"	2
There would be no stigma	1
When people can get help on demand	1
Quicker access to services	1
Increased number of people able to work	1
Service provided for everyone	1
Fewer suicides and suicide attempts	1
Less people traumatized by mental illness	1
People able to lead fulfilling lives	1
Thinking outside the box is valued	1
More people doing what they love to do	1
Less news about people harming themselves or others due to mental illness	1
Fewer community problems	1
No more complaints about the mental health system	1
System Outcomes	**32**
Less police/jail involvement	6
Less time to wait for an appointment	4
Financial assistance available for everyone	3
Decrease in hospitalizations	3
Keep one therapist/case manager throughout treatment	2
Effective mental health facilities where they are needed	2
Better training for mental health workers	2

More people included in the "system"	2
Every person would have health coverage	1
Increase in federal funding	1
Early screening for everyone	1
More staff and lower caseloads	1
Decrease in incarceration of people with mental health issues	1
Increased number of people enrolling in services	1
CIT would be mandatory for all police officers	1
Service availability/information would get to potential consumers	1
Outcomes Related to Youth	**12**
Children growing up to be loving and self-supporting	2
More kids graduating from high school/college	2
Less number of teens being arrested	2
Youth with problems identified earlier on	1
Youth would have more of a voice	1
Fewer teenage suicides	1
Youth able to access mental health services in schools without stigma	1
Happier kids and fewer hospital stays	1
Less number of teens being sent to foster care	1
Outcomes Related to Adults/Families	**6**
Facilities working for the best interests of families	2
Divorce rates for parents with mentally ill children going down	1
People would be working and happy again	1
Decrease in family dysfunction	1
Less people on public assistance	1
Outcomes Related to Older Adults	**2**
When older adults are treated as well as everyone else	1
Seniors shouldn't have copays	1

Summary of Responses to Prompts about the Six New Freedom Commission on Mental Health Goal Areas

Table 4 presents results of a qualitative analysis of responses given by individuals interviewed regarding Washington State's achievement of the six New Freedom Commission Goals. The following summary presents some of the main themes, concerns, and suggestions provided by individual consumers in response to prompts about the 6 New Freedom Commission Goals. Many of the ideas correspond with those from Table 2, as they are essential to changing the mental health system. A summary of findings is presented below:

- The **stigma** of having a mental health issue, or a family member with a mental health issue, affects one's ability to get jobs, maintain custody of children, parents ability to be involved in their child's education, and overall ability to feel safe asking for the help they require.
- A primary theme with regard to the stigma experienced by consumers and their families is the **need for public education** about mental health issues, especially for teachers and other professionals involved in assisting this population. Also mentioned was some form of **education within the school system** to help combat the stigma associated with youth who have mental illness.

- Many consumers recommend that **housing** be provided for all individuals as a baseline need. They identified that it is difficult to treat people with mental health issues if they are lacking basic necessities.
- **More coordination** is necessary between services, agencies, and providers in order to provide quality care to consumers. Continuity of providers throughout treatment was also mentioned as a necessary change (i.e., not switching providers every couple of months).
- **Culturally and linguistically appropriate services, services in rural communities, and specialty services** such as access to psychiatrists, were identified as lacking throughout the interviews.
- The **length of time** that it took to become involved in services was an issue for many consumers. Locating a provider, going through the intake process, being assigned to a clinician, and beginning treatment were just a few steps mentioned as barriers to accessing services. This process can take several months at times and is not conducive to assisting people when they actually need the help.
- The need for **greater access** was discussed Many individuals go through the emergency room, their church, or jail to receive services. Children often become ineligible for services based on age constraints, and the family is then left to find new services.
- **Financial constraints** placed on families, including **issues with insurance**, were common. It was recommended by several consumers that the state provide healthcare to every person, regardless of income or job status. Overall, it was recommended that **mental health care be more affordable and accessible**.
- People did report that they felt they were receiving excellent care, although several did feel that the care they received had been very poor. Consumers mentioned that it would be helpful to have an **advocate to navigate the system** with them.
- Consumers offered a variety of **suggestions for future research**, focusing mainly on the reasons for different diagnoses and options for treatment. The **internet** was cited as being useful for many consumers, although several mentioned that they did not have the access or experience to utilize the information found online.

Table 4.

Results of Qualitative Analysis of Responses Regarding New Freedom Commission Goals

Themes	N Statements
Goal 1: Recognizing that Mental Health is Essential to Overall Health: Stigma in Washington State	**104**
Solutions	**36**
Educate physicians, teachers, and the public to reduce stigma	15
Incorporate anti-stigma education into schools	7
Promise, NAMI Club, Clubhouse, and life skills are helping with stigma	5
Respect for all individuals with mental illness	3
Positive representation in the media	3
More coordination between service agencies	1
Youth In Action program	1
Provide housing for all homeless individuals	1
Diagnosis and Treatment	**26**
Feel comfortable talking with their doctor/nurse/counselor	12
Physicians often require physical symptoms before examining mental ones	2
More difficult in rural communities to receive treatment due to stigma	2

Need accurate diagnoses that don't label people	1
Depression is not seen as a mental illness	1
Counselors blame parents for their child's diagnosis	1
Definite stigma attached to diagnosis of autism	1
Need to address issues other than just treatment (i.e., homelessness)	1
Medical discharge from the military creates stigma	1
Medication use increases the stigma	1
Incarceration due to mental illness creates stigma	1
People feel judged for past abuse they may have experienced	1
Difficult to gain custody of children because of stigma	1
Pay attention to cultural implications of diagnosis and treatment	1
Life Without Stigma	**31**
No one would have to hear unkind remarks	24
Everyone would feel safe asking for help	5
Parents wouldn't fear that their child would be taken away	1
Parents would not have to worry about what people think of their child	1
Issues in the School System	**6**
No tolerance policies allow schools to "get rid" of mentally ill kids	2
Schools unwilling to work with autistic children	1
Parents do not feel safe asking for help from the school system	1
Kids who act out due to mental illness are blamed for their actions and refused 504's	1
Assumed that parents do not want to be part of kids' education	1
Lack of Consumer Awareness	**5**
Consumers unable to see how their behavior might be caused by mental illness	1
Although antidepressants may be working, consumer feels that they are still just a little tired rather than depressed	1
Refusal to take medication due to feeling labeled	1
Consumer feeling that their family is not succeptible to mental illness	1
People with mental illness often refuse to acknowledge that they need treatment	1
Goal 2: Consumer and Family Directed Treatment: Choices and Ownership in Mental Health Care	**84**
Solutions	**28**
Provide funding for support groups (for clients, parents, partners, etc.)	7
Funding for NAMI programs	4
Coordination of care between providers	3
Involve multiple systems in care	2
Provide local detox center	2
More services for homeless people	2
Provide care for co-occurring disorders	2
Provide evaluation and treatment center that is available 24/7	2
Transportation to and from services	2
More respite care opportunities	1
Provide mental health treatment for people coming out of jail	1
Lack of Choices	**27**
No choice in the type of therapy consumers can receive	10

Able to receive help when needed	7
Need culturally, linguistically appropriate services (especially in rural areas)	4
Not many psychiatrists to choose from	4
Parents have few choices for their children's treatment	2
Getting help is always a choice, unless enforced by the legal system	1
Lack of Resources	**21**
Financial constraints experienced by families	9
Insurance only covers some services	6
Therapy generally too time-constrained	2
Lack of funding provided to mental health services	1
More programs in rural communities	1
Make people aware of available resources	1
More housing, jobs, and competent providers	1
Caseworkers have been extremely unhelpful	1
Treatment Issues	**8**
Often there are too many individuals involved in providing mental health care (i.e., different counselor for each issue)	3
Counselors receive limited information from the client	2
Treatment is not empowering	2
Does not want treatment for illnesses	1
Goal 3: Reducing Disparities and Increasing Accessibility of Services	**67**
Barriers to Accessing Services	**37**
Services are culturally inappropriate	12
Insurance only covers certain services	6
Services take too long	5
Financial constraints of family	4
Never attempted or does not want to access services	3
Unable to seek care due to logistical reasons (i.e., no phone, no language resources, insurance difficulties)	3
Very few services/providers available	2
No access to necessary services for older adults	1
Felt that they would be judged when seeking help for their illness	1
Methods to Obtain Access	**18**
Go to the emergency room	5
Through church	4
Seeks help through family members	3
Get services by going to jail	2
Through doctor	1
Be persistent and assertive in order to receive services	1
Became homeless to receive services	1
Accessibility has never been an issue	1
Use DD to access services	1
Awareness of Resources	**5**
Unsure what services are available	2
Never been refused services	2
After years of dealing with the system, finally know where to get services	1

Solutions	**4**
More crisis services	3
Provide counselors and Ph.D.'s	1
Problems with Intervention	**3**
Often received too late	1
Therapeutic foster care is not set up for mentally ill youth	1
Bypasses least restrictive care setting	1
Goal 4: Early Intervention and Getting Rapid Access to Help	**35**
Barriers to Seeking Help	**22**
"Getting in" to see someone takes a long time	8
Unable to see need for services right away	5
Lack of or inadequate screening and diagnosis	4
Ages of children; services no longer available after a certain age	1
Treatment offered is insufficient compared to need	1
Systems unable to quickly decide on coverage/payment for services	1
Lack of services for children	1
Culturally and linguistically appropriate services unavailable	1
Positive Experiences	**8**
Crisis services provide help quickly	4
Use of friends and/or family for help	2
Case manager very helpful	1
Felt empowered during triage process	1
Referral Sources	**5**
School system referred family to services	2
Jail	1
Family had to seek out services	1
Primary Care Physician	1
Goal 5: Quality of Care and Accelerated Research	**92**
Solutions	**32**
Mental health care should be more accessible/affordable	9
Goal should be to help clients, not to get paid	3
Provide facilities that have medication management and assisted living	3
Provide more local resources (in rural communities)	3
Treatment driven by families and consumers	2
Doctors should acknowledge mental illness as a disease	2
Add more services and qualified clinicians	2
Consumer education regarding mental illness	2
Improved housing opportunities	1
Access to Job Coaches	1
Accessibility for everyone regardless of financial status	1
Provide wraparound services	1
Provide shelters specifically for dealing with mentally ill people	1
Funding to support families going through crisis	1
Community-based family practice that deals only with mental illness	1

Positive Experiences	**25**
Have received excellent care	23
Received helpful treatment while incarcerated (youth)	1
Eastern State Hospital is great	1
Negative Experiences	**16**
Received poor quality of care	4
Lack of respect for clients and family members	3
Lack of consistency between services/providers	3
Client or family dislike of services provided	2
Lack of cultural understanding	2
Too many gatekeepers	1
Has felt like a burden to their providers	1
Program Suggestions	**19**
Able to get in to see someone right away	5
Should be able to see a psychiatrist within one week	3
Better coordination between agencies	2
Helpful to have an advocate to help navigate systems	2
Pay staff better to ensure more qualified people	2
Provide continuity of care (always switching counselors)	2
Provide more services for young children	1
Schools should be set up do deal with kids with mental health issues	1
Make medication available immediately	1
Goal 6: Research and Technology	**87**
Future Research Suggestions	**27**
Study about different diagnoses	9
More options for treatment	3
Depression	3
Medications	3
Need more studies on self-harm	3
Compulsive thinking patterns	2
The causes of mental illness	1
Treatment for sexually abused children	1
Need research that focuses on finding answers	1
Would like to study the NARSAD impact	1
More research on natural alternatives	1
Found Technology Helpful	**25**
Internet has been very useful in obtaining information	22
Can receive information from a variety of methods now (i.e., email)	2
Able to make contact with other families via the computer	1
Found Research Helpful	**15**
Got information from the library	6
Has been helped by mental health research	5
Regularly accesses research via the internet	1
Gets information from MH conferences	1
Impressed with the trend toward evidence-based practice	1
Interested in forming a self-help group because of research	1

Unable to Use Technology	**14**
Does not have a computer or know how to use one	9
Most of the information available is in English	2
Prefers older methods (i.e., the yellow pages)	1
Cannot read or write	1
Never thought of using technology to access information	1
Unable to Access Research	**6**
Has no idea how to obtain information	2
Not able to read well enough to learn from research	2
Doesn't care about research	1
Unable to obtain information on how to help family member	1

Major Themes from Specific Groups

A primary focus of the presentation by team members to the Transformation Work Group was to describe specific issues of concern for populations whose voiced are perceived to be underrepresented. Such separate analyses were ultimately conducted for five special groups, including homeless individuals, Spanish speaking individuals, youths, family members of consumers, and older adults.

Consistent themes emerged in analyzing results of in-depth interviews from these groups, including:

- Access to care
- Having choices
- The need for service integration and coordination
- Help with co-occurring disorders
- The presence of stigma
- Needing someone to listen

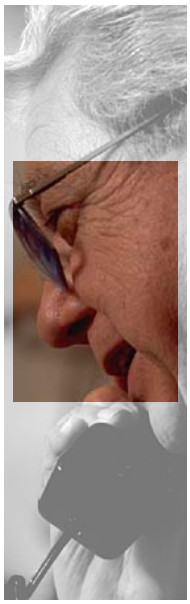
However, there were also themes that were specific to certain groups. Not surprisingly, **homeless individuals** were unanimously insistent that support for their mental health issues required assistance with jobs and housing. All 33 homeless individuals that were interviewed had an experience similar to one 35-year-old African American male: A victim of child abuse, he described suffering from anxiety and post traumatic stress syndrome. Even though he's been clean and sober 8 years, he's unable to find a job or housing. He's on the waiting list for housing, which is 8 to 9 months long. He wants and needs a home and a job with coaching, he wants to be safe. It was stressed by consumers with homeless experiences that **jobs and housing** must be provided to consumers if recovery is truly a goal of the system. Many of these consumers made the point (supported by recent research) that the costs of subsidization of housing and providing job services would probably offset the costs of mental health and other care they often wind up receiving in hospitals and other emergency settings.

Spanish speaking individuals expressed the need for culturally relevant and linguistically appropriate help. In one example, an eighteen-year-old Spanish-speaking female who attends high school has been severely depressed and tried to commit suicide. She is the daughter of migrant workers and has worked in the fields since she was 13. She was diagnosed with PTSD after having experienced sexual assault. She told our interviewer: "I would like to see more mental health available for teenagers with depression, because they do not know how to cope with it. Help teens with problems that can bring depression. The services should be in both languages, English and Spanish."

Youth expressed very clearly a need for help dealing with trauma and rape. One youth expressed the frustration of not being able to access help for the debilitating aftereffects of her previous sexual exploitation. Several young people interviewed expressed that it seemed the only way to make the system pay attention to your needs was to get pregnant or get arrested.

Family members of youth expressed a need for getting support, such as from peer professionals, and access to as much family empowerment as possible. They also frequently cited the stigma of having a child with mental health problems. Coordination of services, such as across child welfare, health, and school settings was viewed as a critical need for many family members of youth with mental health problems.

For **older adults**, it was frequently expressed that it is very important that they are treated with dignity and respect. Older adults share a common theme with youth, the desire to have someone really listen to them. In addition, the need to be able to have coordination of care across health and mental health providers was an oft-expressed need of older adults.



Chapter 4 | **Telephone Survey of Consumers**

JULY 2006

PRELIMINARY | Still Under Review

MENTAL HEALTH CONSUMERS SPEAK

By The Washington Institute for Mental Illness Research and Training
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ABSTRACT

Data Sources: This section was written using data collected by The Washington Institute. The content provides an analysis of the Recovery Oriented Systems Indicators (ROSI) Measure, the Discrimination Experience Subscale, and a series of open-ended questions that were developed collaboratively between the Washington Institute and other stakeholders. This section contains information on the dataset, a discussion of data collection methods, and additional information on data analysis.

Survey Tool: This report presents baseline data using a recovery tool called the Recovery Oriented System Indicators (ROSI) measure, a measure of perceived stigma, and open-ended questions addressing the four major Transformation questions.

Service Satisfaction: Overall, 70 percent of the consumers report being satisfied with staff and with mental health services they receive. However, most of the consumers do not believe that mental health services help them get basic resources such as employment and safe housing – services do not appear to be seen as helping them gain a sense of independence. Thirty-nine percent feel they are rarely or ever supported in getting the education or supports they and their families need to be fully supported.

Access: About 65 to 70 percent report that they can access services when needed. However, access and expanded services were the most frequently mentioned areas needing improvement. Twenty-four percent say they can rarely or never see their therapist when needed, and 13 percent can see them only "sometimes."

Stigma: At least half of the respondents report feeling stigmatized and discriminated against because of their mental illness.

THE WASHINGTON INSTITUTE

ABOUT THE WASHINGTON INSTITUTE

The Washington Institute for Mental Illness Research and Training (Western Branch) is co-affiliated with the University of Washington and the Washington State Department of Social and Health Services, Mental Health Division. Our purpose is to improve collaboration between state government, colleges, and universities — and to conduct training, research, and clinical program development of direct benefit to persons with mental illness.

HIGHLIGHTS | Research Methods and Questions Asked

Key Questions

The current project is part of Washington State's Mental Health Transformation effort and was developed to inform the following four major needs assessment questions:

1. *Within Washington State, what is working well when addressing the needs of mental health consumers?*
2. *Within Washington State, what is NOT working, creates barriers or fails to provide quality service and support when addressing the needs of mental health consumers?*
3. *What would a "transformed" mental health system look like?*
4. *What outcomes would indicate that the changes in the mental health service systems are creating improved results for consumers?*

The Survey Questionnaire

To help answer these questions, a telephone survey of adult mental health consumers was conducted. Information collected by the survey includes demographics such as age, race/ethnicity, gender, and employment status. An instrument was also needed to measure consumers' "recovery" within the mental health system. For this purpose, the Recovery Oriented System Indicators (ROSI) recently developed by Onken (2004) was included. This is a 42-item self-report questionnaire designed to assess consumers' perception of what helps and what hinders mental health recovery within the mental health service system and ties directly to the four major needs assessment questions.

In addition to the ROSI, consumers were also asked questions about whether they felt stigmatized because of their mental illness. An example item is, "People discriminate against me because I have a mental illness."

Seven more general questions were also developed to give consumers the opportunity to express their responses in their own words. These "open-ended" questions were posed in such a way as to reflect upon the four major needs assessment questions stated above. Examples include what they like most and least about the services they have received, and what the ideal mental health system would look like.

ACKNOWLEDGEMENTS

A NOTE FROM THE AUTHORS

The researchers would like to express their sincere thanks to the interviewers who spent numerous hours attempting to contact potential respondents. With extraordinary diligence, the interviewers made thousands of phone calls in order to collect the valuable information used in this report— data that we hope will serve to help transform the way mental health services are delivered in Washington State.

Obtaining viable contact information for participants randomly chosen for this survey proved an onerous chore; this process required significant assistance from the 14 Regional Support Networks (RSNs) and scores of provider agencies throughout Washington State. The researchers would like to thank the RSN Administrators and their staff members for their efforts. We would also like to express our appreciation to countless staff members at the individual provider agencies for their patience and hard work.

Finally, the researchers would also like to thank Liz Kohlenberg and her staff at the Research and Data Analysis (RDA) Division for their assistance and quality of service in providing us with additional contact information.

The Survey Sample

Consumers 18 years old and older that received state funded mental health services from June 1, 2005 to November 30, 2005 were the targeted population. Participating consumers were drawn from two sources, those receiving mental health services from state mental health providers (MHD provider group) and those receiving mental health services from other DSHS service providers that are not state mental health providers (non-MHD provider group). A simple random sample of 1,500 consumers was selected for each group. The samples came from the MHD MIS for the provider group and from the ACES Barcode (Economic Services) for the non- MHD provider group. This report represents 633 consumers who have participated in the survey, 384 from the MHD provider group and 249 from the non- MHD provider group.

Survey Methodology

Survey data were collected using the Computer Assisted Telephone Interview (CATI) system. The CATI system integrates a questionnaire, databases, and a network of linked computers to allow interviewers to obtain information by telephone. Consistent with the intention of the Transformation Grant, most of the interviewers were themselves consumers of mental health services.

Who Participated in the Survey?

Most survey participants were between the ages of 40 and 60 (50 percent). The second largest group was between 21 and 40 years of age (35 percent). Ten percent were 60 to 75 years of age. Three percent were under the age of 21 and only 2 percent were 75 or older. Those respondents in the non- mental health agency group were 4 years older on average than those in the mental health agency group. The majority of the respondents were female (65 percent) and most were white (77 percent). There was a fairly even distribution of Native Americans (5.1 percent), African Americans (5.6 percent), and Hispanics (4.7 percent). Asian or Pacific Islanders had the smallest representation (1.8 percent).

Of those who took the survey, 18 percent said that they were currently employed. The MHD provider group reported a higher rate of employment (16 percent) than the non-MHD provider group (11 percent). This difference may be due to the non-MHD provider group being older.

HIGHLIGHTS | A Summary of Survey Findings

The Dimensions of Recovery

The ROSI was found to measure 6 central dimensions of recovery:

1. *Staff and Treatment Satisfaction*
2. Consumers' perceived *Independence*
3. *Access* to services
4. *Invalidated Personhood* (e.g., consumers feel that they are not understood by staff, and their basic rights are not upheld)
5. Consumers' perceived *Support*
6. Consumers' perceived sense of *Encouragement* from others

While there was considerable variation on these six dimensions of recovery, there were only minor differences in average scale scores on these dimensions between consumers receiving services from MHD and non-MHD providers. Therefore, the discussion to follow will refer to both groups combined unless otherwise stated.

Staff and Treatment Satisfaction. In the area of *Staff and Treatment Satisfaction*, 70 percent of the respondents indicated that they were always or almost always satisfied with the services they received from their mental health provider. Examples of items from the *Staff and Treatment Satisfaction* scale include "Staff listens carefully to what I say" and "Mental health staff helps me build on my strengths." No significant differences were observed when comparisons were made between females and males, minorities and non-minorities, or provider type (i.e. mental health versus non-mental health providers).

Independence. In the *Independence* category, less than half (45 percent) of the respondents agreed or strongly agreed that mental health services helped them get basic resources such as employment, housing, and education. Items comprising this scale include "Services help me develop the skills I need" and "Mental health services helped me get housing in a place I feel safe." Compared with respondents who received services from mental health providers, respondents who received services from non-mental health providers felt their services were less likely to help them get basic resources. No significant differences were noted for gender or minority status.

Access. In the category of *Access* (Figure 13), 70 percent of the respondents agreed or strongly agreed that they had access to services. Items in this scale include "I (can) get the services I need when I need them" and "I can see a therapist when I need to." Almost two-thirds (63 percent) of the respondents indicated that they can always, almost always, or often see a therapist when they need to; 13 percent can see them sometimes; 24 percent say that they can never or rarely see their therapist when needed. No significant differences were noted for gender, minority status, or agency type.

Invalidated Personhood. Sixty percent of the respondents disagreed or strongly disagreed with the *Invalidated Personhood* category. Items comprising this scale include "The mental health staff ignores my physical health" and "Staff does not understand my experience as a person with mental health problems." Respondents receiving services from non-MHD providers reported feeling more invalidated than respondents receiving services from MHD agencies. Likewise, non-minorities reported feeling less validated than minority participants. No differences were noted on this scale for gender.

Supports. In the category of *Supports*, 55 percent of the respondents felt supported often, almost always, or always by the mental health services they received. 22 percent felt supported sometimes, and 23 percent rarely or never felt supported. Items from this scale include "I have information or guidance to get the services and support I need, both inside and outside my mental health agency" and "My family gets the education and supports they need to be helpful to me." Male respondents perceived more support than female respondents. No significant differences were observed for minority status or agency type.

Encouragement. In the category of *Encouragement*, 81 percent agreed or strongly agreed that they were encouraged by the mental health services they received. Examples of items from the Encouragement scale include "I am encouraged to use consumer-run programs (for example: support groups, drop-in centers, etc.)" and "There is at least one person who believes in me." Male respondents were more likely to report feeling encouraged than were female respondents. No significant differences were reported for minority status or agency type.

Stigma

For the *Discrimination Experience* scale, over half of the respondents (51 percent) felt stigmatized due to their mental illness. Items from this scale include "Others think I can't achieve much in life because I have a mental illness" and "People discriminate against me because I have a mental illness." No significant differences were noted for gender, minority status, or provider type.

Open-ended Questions

As noted above, seven open-ended questions were offered to consumers to allow them to express in their own words experiences and opinions that would reflect upon the four major needs assessment questions of the Transformation project. Questions include what they liked most and least about the services they received, what they think is working well and not working well in the mental health system, what things could be done to make their life better, and what the ideal mental health system would look like to them.

Open-ended responses were separated out by those with higher scores on the ROSI from those with lower scores on the ROSI. This was done to compare the concerns and opinions of persons who perceive the system as being recovery-oriented with persons who do not perceive the system as being recovery oriented. The responses described below represent all the responses that were made for each question and corresponding percentages represent the proportion of people in each group who mentioned that category.

What two things do you like most about the mental health services you received?

The most common response to this question was "Staff." Staff was mentioned by 46 percent of the participants who perceive the system as being recovery oriented and by 30 percent of the persons who perceive the system as not being recovery oriented. "(The staff's) attitude when you first go in to see them… (they) seem to understand" is a typical response.

What about the mental health system in your opinion is working well?

The highest percentage of respondents did not comment on this question when asked. For respondents who believe the system is recovery oriented, "Service Availability" (25 percent) was the most common response. Twenty-nine percent (29 percent) of the participants who believe the service system is not recovery oriented made a negative comment when asked this question. "I like the line is open so you can talk anytime of the night" represents a typical response.

What two things do you like the least about the mental health services you received?

The most common response to this item was "Staffing/Appointment" issues. For those with a non-recovery orientation to the system, "Lack of Services/Termination" of services was the second most common response (35 percent). Nineteen percent of persons who believe the system is recovery oriented did not comment on this issue. A typical response was, "I had a lot of therapists that would constantly be changed."

What about the mental health system in your opinion is NOT working well?

"Lack of Funding" for mental health services was the most common response to this question. "Lack of Therapists/Staff" was the second most common response (25 percent) of people who believe the system is not recovery oriented. "Not enough therapists, too many patients" is a typical response.

If you were giving advice to the mental health decision-makers in Washington State, what two things would you tell them that they or staff could do to make your life better?

Improving "Access to Programs/Better Treatment" was the most common response to this question for both groups. The second most frequent response was "Staffing issues," which includes references to lower caseloads and more money for staff. A typical response was "More funding or ways to help others afford services and meds for those who want to make their life better"

What would the ideal mental health system look like to you?

"Better Treatment" was the most common response to this question for both groups. "More treatment for people with drugs and alcohol (issues), and better housing, more money, and more extensive services" was a typical response.

If the mental health system changed, how would you know it is moving in a positive direction?

"Greater Access to Services" was the most common response to this question. A typical response was "By the number of people getting treatment and showing positive results."

The Survey and Respondents

Key Questions

To answer the questions identified in the previous section, a telephone survey was developed that included demographic (e.g., gender), open-ended (e.g., "What would the ideal mental health system look like to you?") and close-ended questions (e.g., "Mental health services helped me get or keep employment."). Close-ended questions were taken from the Recovery Oriented System Indicators (ROSI) measure and the Internalized Stigma of Mental Illness (ISMI) Scale. Open-ended questions were developed collaboratively by the Evaluation Design Workgroup and were designed to answer the four major needs assessment questions listed above. Demographic questions included employment information, marital status, living situation, age, race, gender, and whether the respondent was currently receiving Medicaid or Medicare health insurance.

Survey data were collected using the Computer Assisted Telephone Interview (CATI) system. The CATI system integrates a questionnaire, databases, and a network of linked computers to allow interviewers to obtain information by telephone. Consistent with the intention of the Transformation Grant, most of the interviewers were themselves consumers of mental health services.[1] Hiring mental health consumers to administer the surveys proved to be a successful strategy. Not only were the interviewers sensitive to the needs and perspectives of the respondents they were interviewing, they also understood the importance of client confidentiality and data integrity. The interviewers did not divulge their status as consumers of mental health services during interviews.

Survey Participants

The decision to sample those receiving mental health services from both state mental health providers and separately from DSHS service providers that are not mental health providers was made by the Transformation Workgroup Evaluation Committee. The targeted number was 1500 from each of the two populations. Based upon past surveys we anticipated completing @ .33, resulting in @500 completions from each population.

The State Mental Health Division (MHD) produced the sample frame (N = 63,687) for the mental health providers. The data were taken from the MHD MIS data system. Consumers 18 and older that received State funded mental health services from June 1, 2005 to November 30, 2005 are the targeted population. A simple random sample of 1500 was then selected from the sample frame.

The sample for consumers receiving mental health services from non-mental health providers was obtained from The Washington State Research and Data Analysis Division (RDA). The sample included adults with DSHS medical coverage identified through medical claims as having an ICD-9-CM mental illness diagnosis in their medical claims in the 6-month period and not receiving services funded through the Mental Health Division.

The sample frame included 23,427 persons. A simple random sample of 1500 was selected from the sample frame. A simple random sample was drawn from the ACES Barcode Data system.

This survey was conducted between March and June 2006. **633** consumers participated in the survey, yielding a completion rate of 21 percent of the total drawn sample. **384** (26 percent) of the participants received mental health services from publicly funded mental health service providers (The Mental Health Provider Group) and **249** (17 percent) participants received mental health services from other providers (The Non-mental Health Provider Group). The last CATI disposition is presented in Table 1.

[1] Interviewers came from three sources: 14 consumers (Rose house and TACID), 4 non-consumer/non-student, and 3 work-study students, for a total of 21. Five were returning. All went through training. New interviewers (16) received two days of training. Several received additional training according to their needs.

TABLE 1.

Last CATI Disposition*	MENTAL HEALTH		NON-MENTAL HEALTH	
	Number	Percent	Number	Percent
1. Disconnect	223	14.9	247	16.5
2. Wrong Number	316	21.1	341	22.7
3. No Answer	25	1.7	32	2.1
4. Answering Machine	26	1.7	19	1.3
5. Busy	9	.6	4	.3
6. Language Barrier	39	2.6	52	3.5
7. Already Responded	7	.5	3	.2
8. Unavailable	104	6.9	129	8.6
9. Hard Refusal	173	11.5	130	8.7
11. Callback/Not at home	1	.1	4	.3
13. Mid-Terminate	10	.7	7	.5
14. Complete	384	25.6	249	16.6
15. No Mental Health Services Received	31	2.1	122	8.1
16. Deceased	17	1.1	18	1.2
17. Mail Survey	15	1.0	10	.7
18. Left Message with Friend or Relative	45	3.0	42	2.8
19. No Longer at this Number	75	5.0	90	6.0
TOTAL	**1,500**	**100.0**	**1,500**	**100.0**

*Numbers above represent the codes that the software uses to identify dispositions. Dispositions 10 and 12 did not come up in the survey, thus do not appear.

Representativeness

The goal of collecting survey information is to be able to "generalize" the findings to the larger population of interest. To do this, a comparison is be made to determine whether the characteristics of the respondent sample (i.e., those who completed the survey) is similar to that of the overall sample – and hence, the consumer population in general. Ideally, the characteristics of the survey participants should match the characteristics of all the persons in the drawn, or total sample. This process is known as determining the participant samples' "representativeness." An analysis of the participant samples' representativeness is presented in Figures 1, 2, and 3.

FIGURE 1.

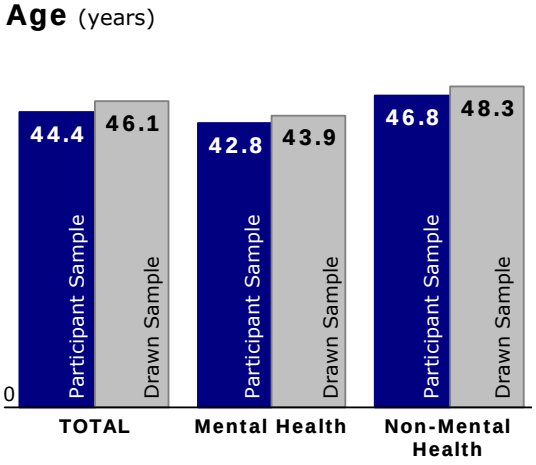
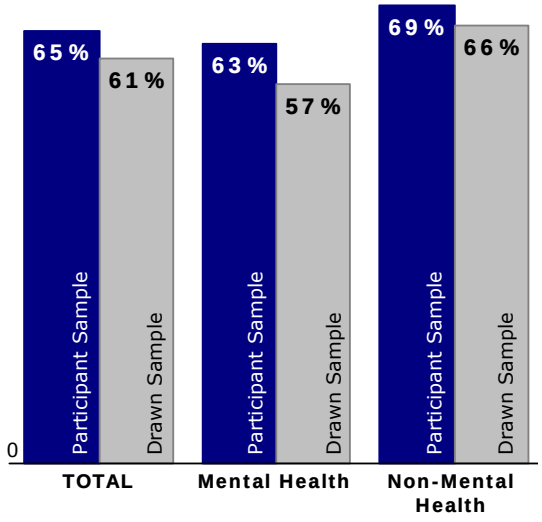


Figure 1 shows that those participating in the survey are younger than those in the drawn sample. This is the case for the total, mental health (MH), and non-mental health (Non-MH) groups. This is typical of survey data in that those that are younger are more likely to be able to participate in the survey; those that are older are more likely to suffer from dementia or other disorder that limits their participation. It should also be noted that the average age of those in the non-mental health group is approximately four years older on average than those in the mental health group.

FIGURE 2.

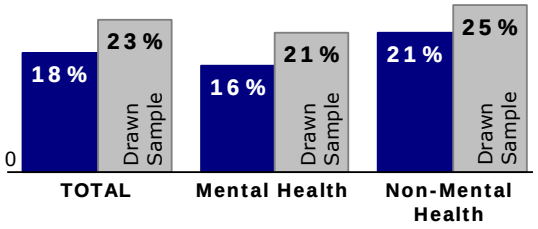
Gender (Percent Female)



In Figure 2, the total percentage of women who participated in the survey (65 percent) is slightly higher than the total percentage of women in the drawn sample (61 percent). Likewise, the percentage of women from the mental health group who participated is higher (63 percent) than those in the drawn sample (57 percent). The percentage of women in the non-MH group who participated is also higher (69 percent) than in the drawn sample (66 percent). The percentage of women surveyed is slightly over-represented from the drawn sample. This is typical of surveys as women are more likely to be found at home during calls than are men.

FIGURE 3.

Minority Status (Percent Minority)



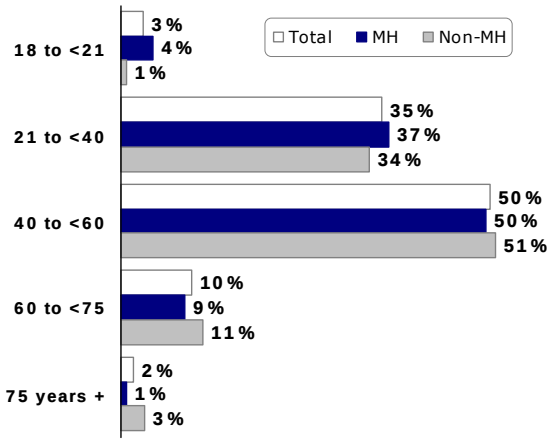
The total percentage of survey participants who identified themselves as belonging to a minority group is lower than that found in the drawn sample (18 percent vs. 23 percent).

Demographics of the Respondents

Demographic items from the survey include questions that asked about the participant's age, race or ethnicity, employment status, and other life circumstances.

FIGURE 4.

Age Category (Percent Respondent)



Those persons eligible to be surveyed were 18 years or older. Figure 4 shows that half of the participants were between the ages of 40 and 60 years old, followed by people between the ages of 21 and 40. The fewest participants were either over the age of 75 years or under the age of 21 years. Fourteen percent of those in the non-mental health agency group were 60 and older compared to 9 percent in the Mental Health Agency group.

FIGURE 5.

Race / Ethnicity (TOTAL)

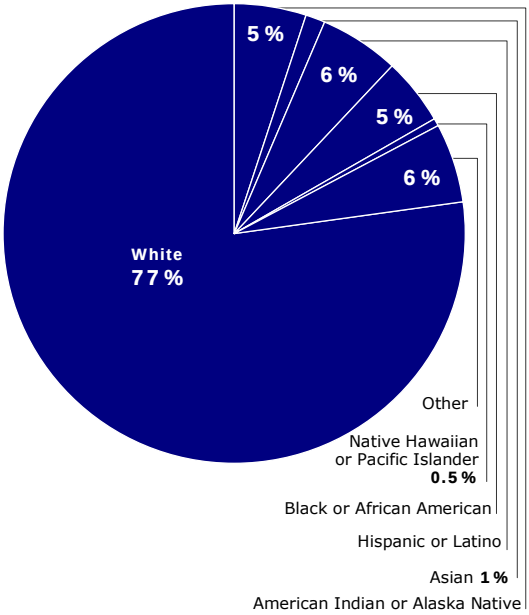


Figure 5 shows that approximately three quarters (77.2 percent) of the participants indicated that their race or ethnicity was White. Participants who identified themselves as "Other," (5.6 percent) or who said they were Black or African American (5.6 percent) made up the next largest categories, followed by American Indian or Alaskan Native (5.1 percent), Hispanic or Latinos (4.7 percent), and Asian (1.3 percent). Less than one percent of the participants said they were Native Hawaiian or Pacific Islanders.

The proportion of Hispanics is much lower in the Mental health Agencies group than the Non-mental health agencies group. The percentage of Hispanics should be at 6 percent not 3.7 percent as indicated in Figure 6.

The proportion of American Indians/Alaskan Natives was twice as large in the Non-mental health agencies group (7.4 percent) compared with the Mental health agencies group (3.7 percent).

FIGURE 6.

Race / Ethnicity (Mental Health Agencies)

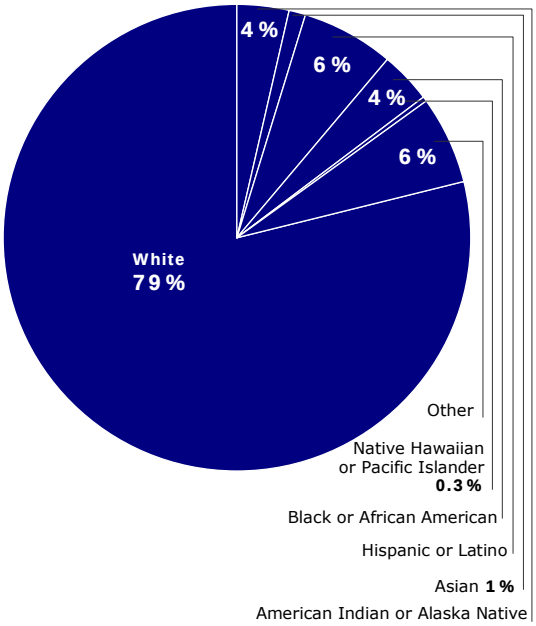


FIGURE 7.

Race / Ethnicity (Non-Mental Health Agencies)

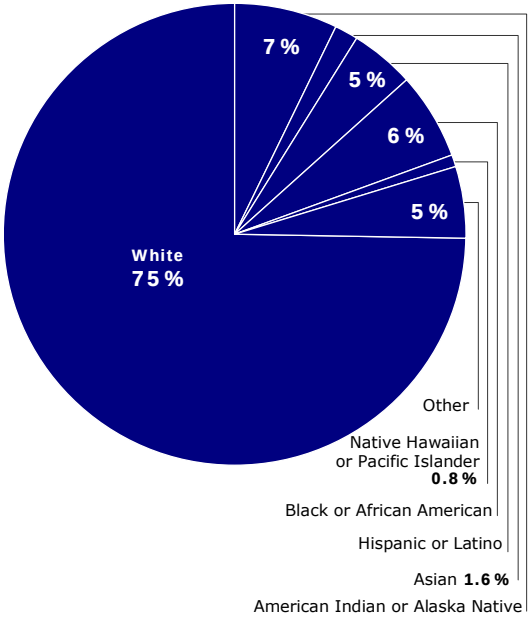


FIGURE 8.

Employment Status (TOTAL)

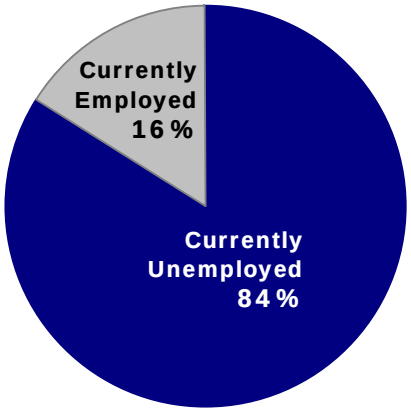


Figure 8 shows that most of the people who completed the survey from either mental health or non-mental health agencies were not currently employed. A larger number were employed from mental health agencies (18 percent) than were employed from non-mental health agencies (11 percent), Figures 9 and 10.

FIGURE 9.

Employment Status (Mental Health Agencies)

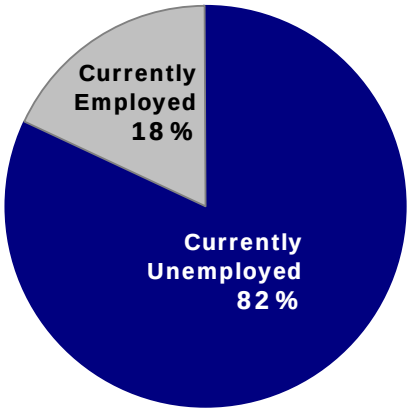
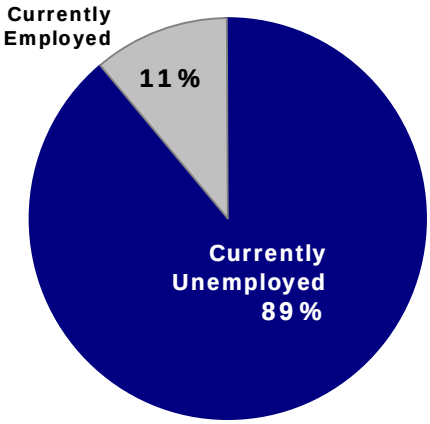


FIGURE 10.

Employment Status (Non-Mental Health Agencies)



The Recovery Oriented System Indicators (ROSI) Measure

The ROSI is a 42-item self-report questionnaire designed to assess what helps and what hinders mental health recovery at the systems-level. Ideally, the ROSI is a "report card" that can be used across time to measure changes, both positive and negative, within a mental health system.

The ROSI is a recently developed instrument that has little technical information. One objective in this first survey is to determine whether the scale is multidimensional and, if so, what are the dimensions, or components.

Onken (2004) identified eight components resulting from a factor analysis done on the 42 item consumer survey items. The eight components include:

1. Person-Centered Decision Making and Choice
2. Invalidated Personhood
3. Self-Care and Wellness
4. Basic Life Resources
5. Meaningful Activities and Roles
6. Peer Advocacy
7. Staff Treatment Knowledge
8. Access

Onken (2004) reported nothing on what type of factor analysis was used, the sample size, factor loadings or other technical information. Therefore, we conducted our own factor analysis. Appendix 1 and 2 show the loadings that we obtained from our factor analysis.[2] Appendix 1 shows the item loadings that we obtained matched to the item components reported by Onken (2004). While there are some common loadings, generally our item loadings do not match well with components reported by Onken (2004). Therefore, we constructed our own scales based upon the item loadings that we obtained. The components and item loadings appear in Appendix 2. The components obtained were then tested for reliability using Cronbach's Alpha, a common measure of internal consistency of scaled items. We consider alphas of .7 or better to be a reliable scale. The components, along with their corresponding Alpha's appear in the Table below.

TABLE 2.

Scale and Reliability Alphas	Reliability ALPHA
Staff and Treatment Satisfaction Scale	**.931**
My right to refuse treatment is respected. (Always…Never) Staff give me complete information in words I understand before I consent to treatment or medication. (Always…Never) Staff listen carefully to what I say. (Always…Never) Mental health staff support my self-care or wellness. (Always…Never) Staff see me as an equal partner in my treatment program. (Always…Never) Staff encourage me to do things that are meaningful to me. (Always…Never) Staff treat me with respect regarding my cultural background (think of race, ethnicity, religion, language, age, sexual orientation). (Always…Never) Staff believe that I can grow, change and recover. (Always…Never) Mental health staff help me build on my strengths. (Always…Never) I have a say in what happens to me when I am in crisis. (Always…Never) Staff stood up for me to get the services and resources I needed. (Always…Never) My treatment plan goals are stated in my own words. (Always…Never) The doctor worked with me to get on medications that were most helpful for me. (Always…Never) Mental health staff interfere with my personal relationships. (Never…Always) I am treated as a psychiatric label rather than as a person. (Never…Always)	
Independence Scale	**.768**
I have enough income to live on. (Strongly Agree…Strongly Disagree) Mental health services helped me get or keep employment. (Always…Never) Services help me develop the skills I need. (Strongly Agree…Strongly Disagree) I have a chance to advance my education if I want to. (Always…Never) Mental health services helped me get housing in a place I feel safe. (Strongly Agree…Strongly Disagree) There was a consumer peer advocate to turn to when I needed one. (Always…Never)	

[2] Our factor analysis was done using principle components extraction with Varimax rotation (N = 480).

Access Scale	**.692**
I do not have enough good service options to choose from. (Strongly Disagree…Strongly Agree) I do not have the support I need to function in the roles I want in my community. (Strongly Disagree…Strongly Agree) I cannot get the services I need when I need them. (Strongly Disagree…Strongly Agree) I can see a therapist when I need to. (Always…Never) I have reliable transportation to get where I need to go. (Always…Never)	

Invalidated Personhood	**.699**
Mental health services led me to be more dependent, not independent. (Strongly Disagree…Strongly Agree) Staff do not understand my experience as a person with mental health problems. (Strongly Disagree…Strongly Agree) The mental health staff ignore my physical health. (Strongly Disagree…Strongly Agree) I lack the information or resources I need to uphold my client rights and basic human rights. (Strongly Disagree…Strongly Agree)	

Supports Scale	**.652**
There are consumers working as paid employees in the mental health agency (service agency) where I receive services. (Always…Never) I have information or guidance to get the services and support I need, both inside and outside my mental health agency. (Always…Never) My family gets the education or supports they need to be helpful to me. (Always…Never)	

Encouragement Scale	**.619**
There is at least one person who believes in me. (Strongly Agree…Strongly Disagree) I am encouraged to use consumer-run programs (for example: support groups, drop-in centers, etc.). (Strongly Agree…Strongly Disagree) Staff respect me as a whole person. (Strongly Agree…Strongly Disagree) Mental health services helped me get medical benefits that meet my needs. (Strongly Agree…Strongly Disagree)	

Scales by Agency Type

The following figures (11 through 17) show scale scores of respondents by agency type.[3] Figure 11 shows the average scores for each of the scales by agency and for the agencies combined. There is little difference in scale score averages between the two agency types.

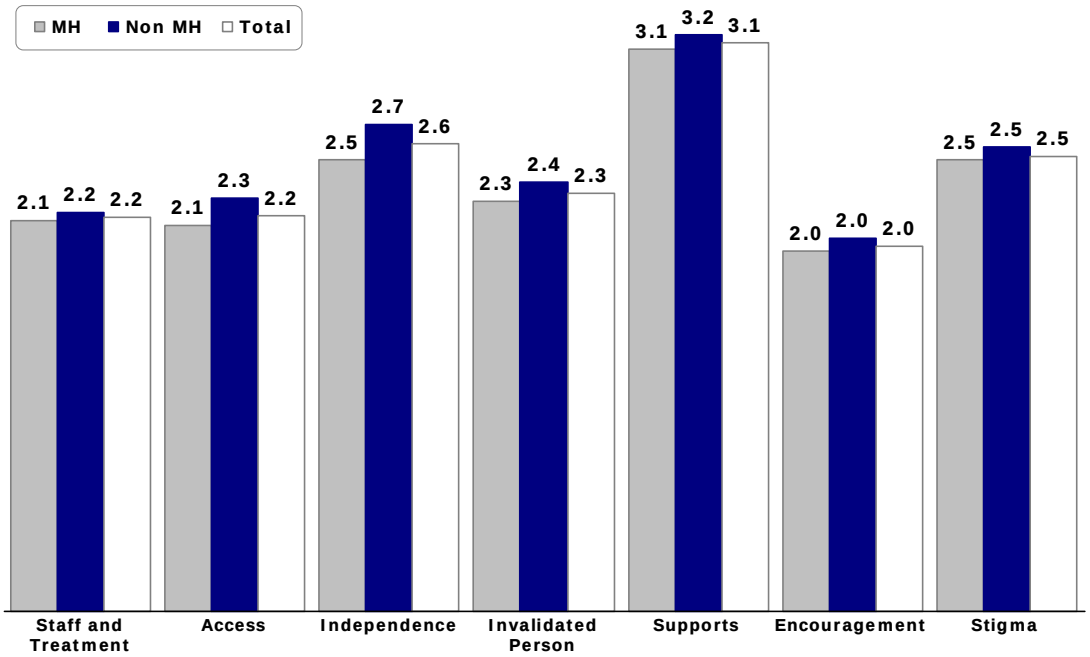
In Figures 12 through 17 the average scale scores were collapsed into categories so that the approximate percentage of scores falling into each of the categories can be observed. There are two response categories for the scales (Strongly agree (1- 1.49), Agree (1.5-2.49), Disagree (2.5-3.49), Strongly disagree 3.5-4.0) and (Always (1-1.49), Almost always (1.5-2.49), Often (2.5-3.49), Sometimes (3.5-4.49), Rarely (4.5-5.49), Never 5.5-6.0)).

For the **ROSI scales**, *positive scores for scales are the lowest scores; higher scores indicate dissatisfaction with the items.*

[3] Scale items were recoded to calculate same direction scale scores and to equalize number of response categories.

FIGURE 11.

Scale Scores (Mean) **by Agency Type**

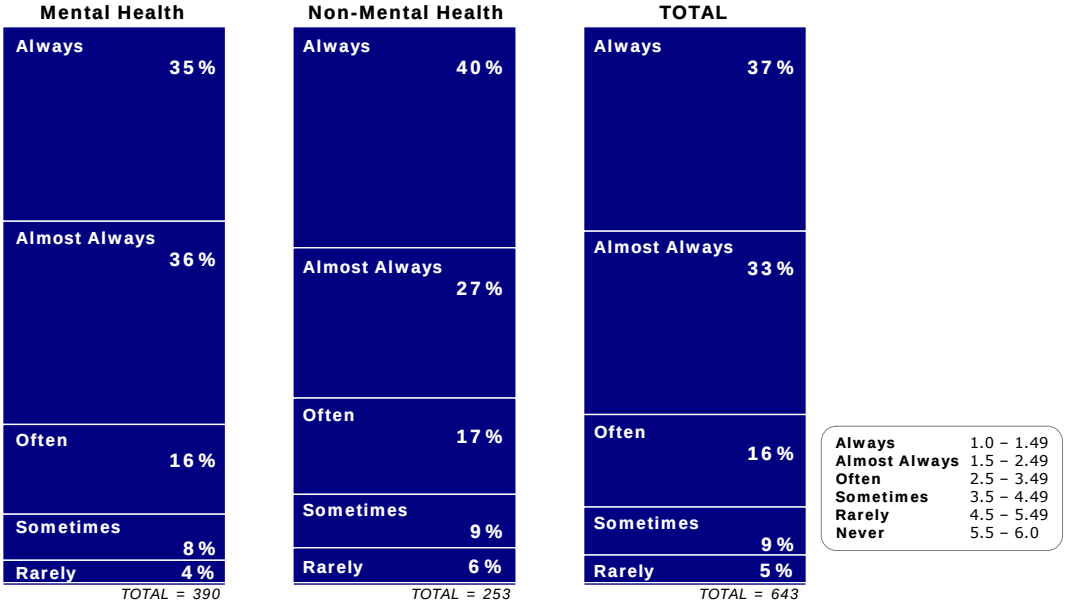


Staff and Treatment Satisfaction

In the area of *Staff and Treatment Satisfaction* (Figure 12) 70 percent of the respondents indicated that they were Always or Almost always satisfied with the services they received from their mental health provider. Less than 6 percent said that they were Rarely or Never satisfied with the staff and treatment they received. No significant differences were observed when comparisons were made between females and males, minorities and non-minorities, and provider type (i.e. mental health versus non-mental health providers).

FIGURE 12.

Staff and Treatment Satisfaction by Agency Type

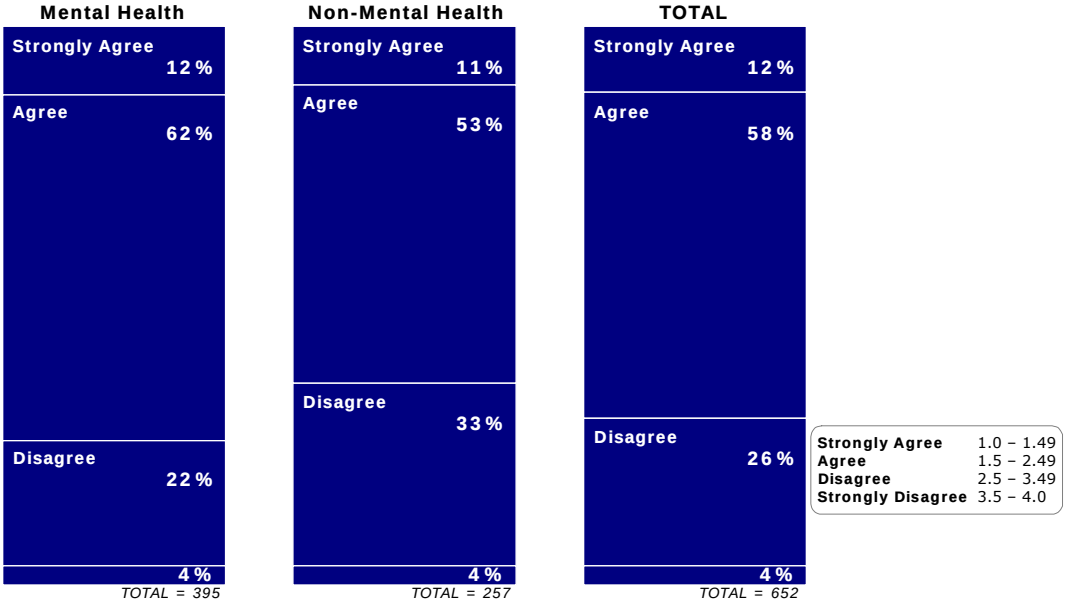


Access to Services

In the category of *Access* (Figure 13), 70 percent of the respondents Agreed or Strongly agreed that there had access to services. Items in this scale include "I (can) get the services I need when I need them" and "I can see a therapist when I need to." Almost two-thirds (63 percent) of the respondents indicated that they can Always, Almost always, or Often see a therapist when they need to; 13 percent can see them Sometimes; *24 percent say that they can Never or Rarely see their therapist when needed.* No significant differences were noted for gender, minority status, or agency type.

FIGURE 13.

Access by Agency Type



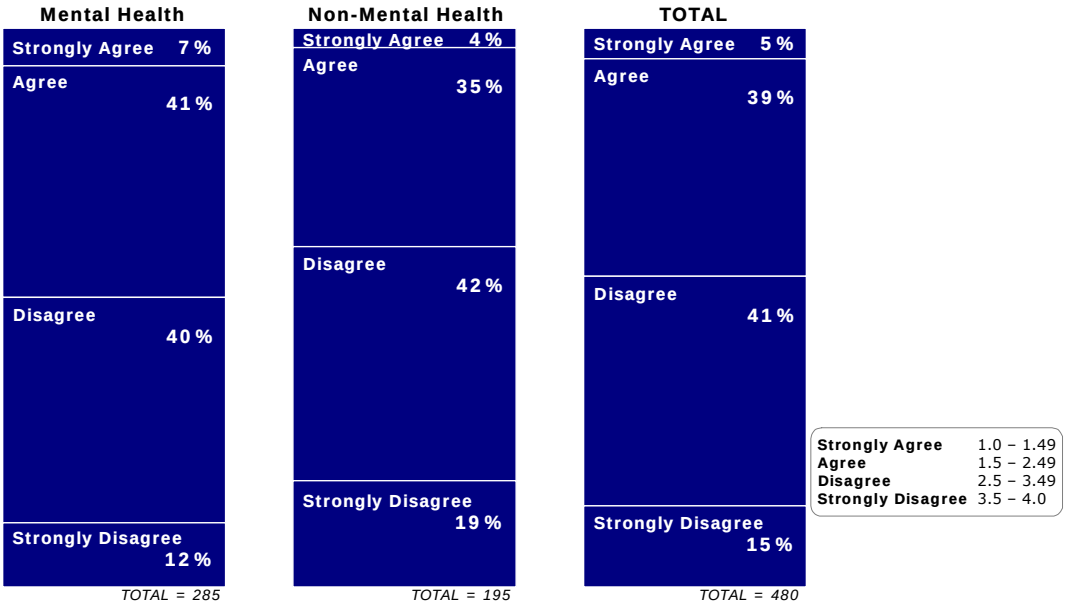
Perceived Independence

In the *Independence* category, less than half (44 percent) of the respondents Agreed or Strongly agreed that mental health services helped them get basic resources such as employment and housing. Items comprising this scale include "Mental health services helped me get housing in a place I feel safe," and "Mental health services helped me get or keep employment." Most respondents (56 percent) reported that they have *Never* been helped by mental health services to get or keep employment (table not shown).

Compared with respondents who received services from MHD providers, respondents who received services from non-MHD providers felt their services were less likely to help them get basic resources (51 percent vs 62 percent). No significant differences were noted for gender or minority status.

FIGURE 14.

Independence by Agency Type

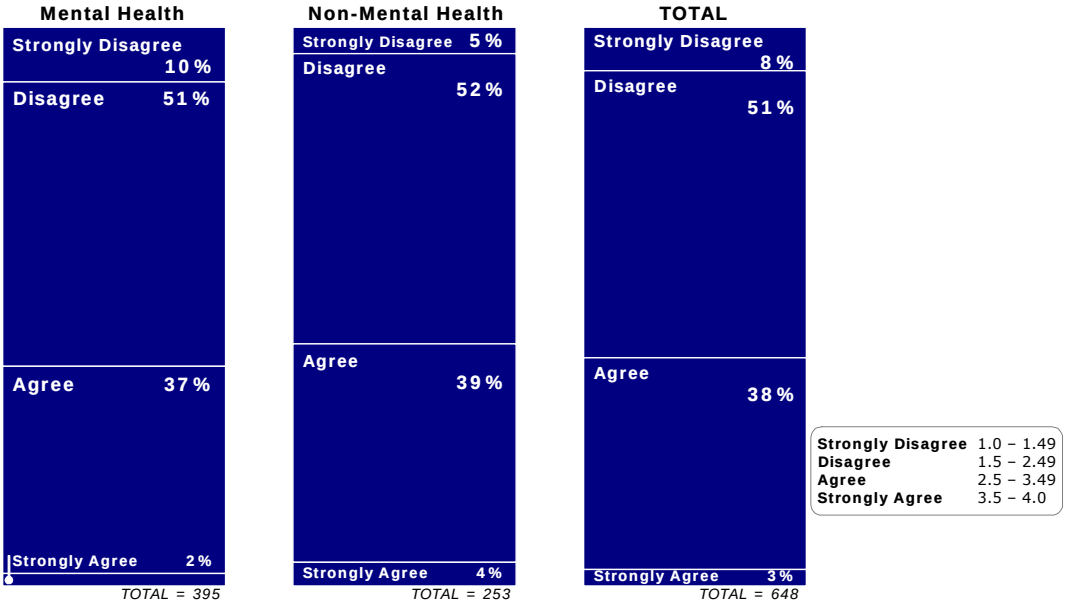


Invalidated Personhood

Fifty-nine percent of the respondents Disagreed or Strongly disagreed with the *Invalidated Personhood* category. Items comprising this scale include "The mental health staff ignore my physical health" and "Staff do not understand my experience as a person with mental health problems." Respondents receiving services from non-MHD providers reported feeling invalidated more than respondents receiving services from MHD agencies. Likewise, non-minorities reported feeling validated less than minority participants. No differences were noted on this scale for gender.

FIGURE 15.

Invalidated Personhood by Agency Type

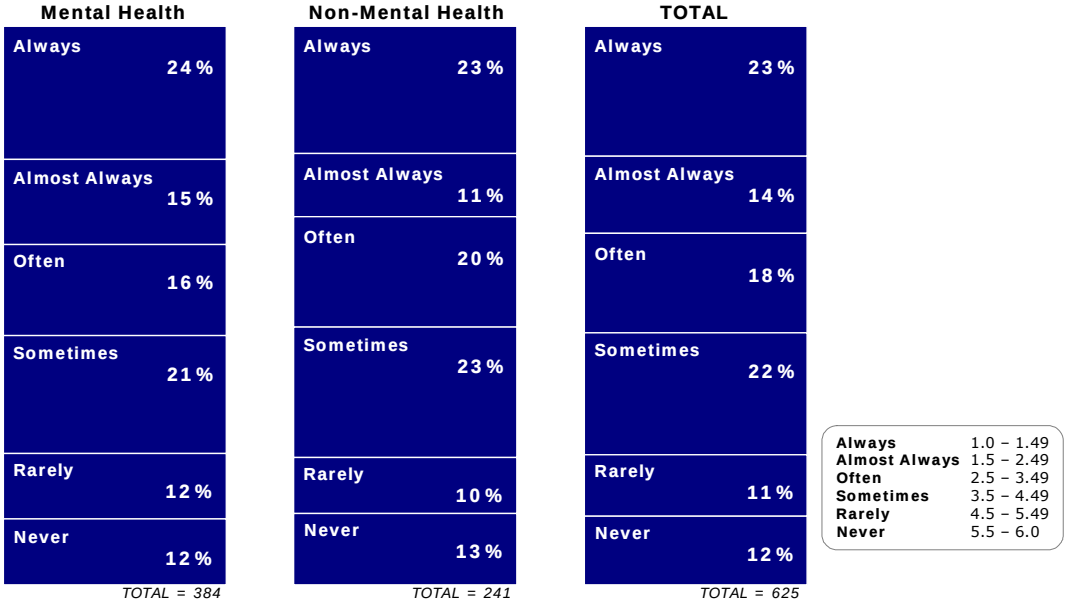


Support

In the category of *Supports*, 55 percent of the respondents felt supported Often, Almost always, or Always by the mental health services they received. 22 percent felt supported Sometimes, and 23 percent Rarely or ever felt supported. Items from this scale include "I have information or guidance to get the services and support I need, both inside and outside my mental health agency" and "My family gets the education and supports they need to be helpful to me." Male respondents perceived more support than female respondents. No significant differences were observed for minority status or agency type.

FIGURE 16.

Supports by Agency Type

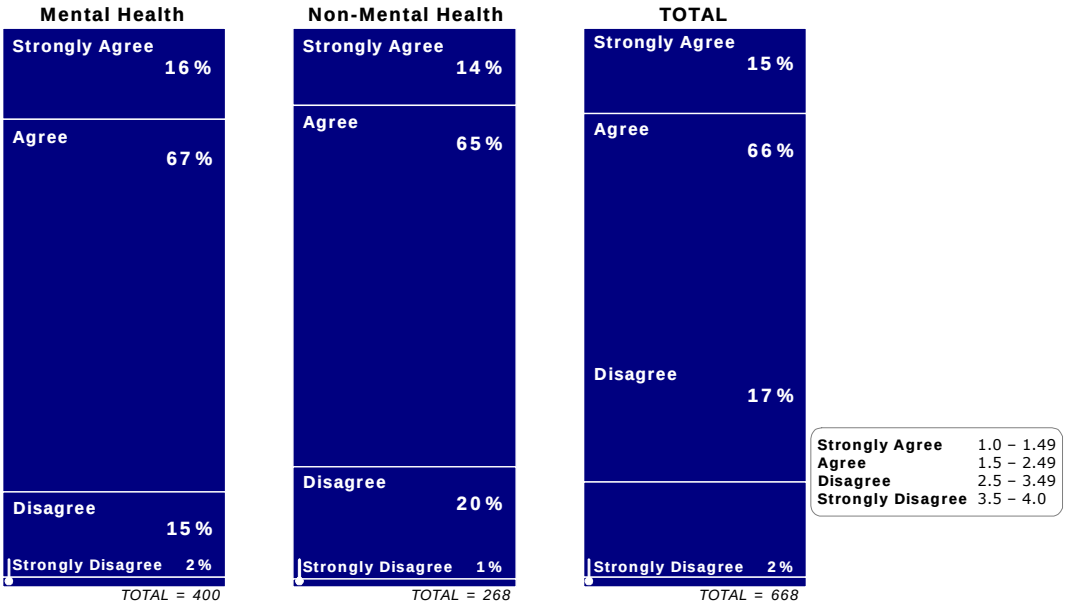


Encouragement

In the category of *Encouragement*, 81 percent Agreed or Strongly agreed that they were encouraged by the mental health services they received. Examples of items from the Encouragement scale include "I am encouraged to use consumer-run programs (for example: support groups, drop-in centers, etc.)" and "There is at least one person who believes in me." Male respondents were more likely to report feeling encouraged than were female respondents. No significant differences were reported for minority status or agency type.

FIGURE 17.

Encouragement by Agency Type



The Discrimination Experience Subscale

The Discrimination Experience Subscale is part of the Internalized Stigma of Mental Illness (ISMI) Scale and was designed to assess the respondents' perception of the way they are treated by other people (Ritsher, Otilingam, and Grajales, 2003). The scale shows a high degree of reliability as measured by Cronbach's Alpha.

TABLE 3.

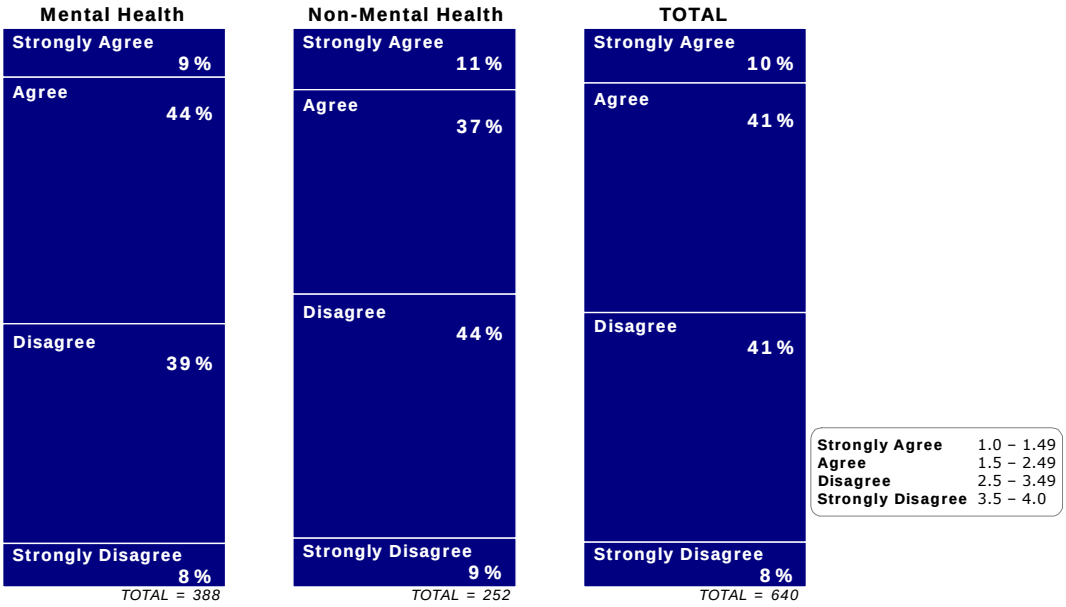
Discrimination Experience Scale	Reliability ALPHA
Discrimination Experience Scale	**.852**
People discriminate against me because I have a mental illness. (Strongly Agree…Strongly Disagree) Others think I can't achieve much in life because I have a mental illness. (Strongly Agree…Strongly Disagree) People ignore me or take me less seriously just because I have a mental illness. (Strongly Agree…Strongly Disagree) People often patronize me, or treat me like a child, just because I have a mental illness. (Strongly Agree…Strongly Disagree) Nobody would be interested in getting close to me because I have a mental illness. (Strongly Agree…Strongly Disagree)	

Figures 18, 19, and 20 show the stigma responses by agency type, minority status, and gender. For the **stigma scale**, *lower scores indicated a higher degree of perceived stigma*.

For the *Discrimination Experience* scale, over half of the respondents (51 percent) felt stigmatized due to their mental illness. No significant differences were noted for gender, minority status, or provider type.

FIGURE 18.

Stigma by Agency Type



Open-ended Questions

In the Transformation Grant survey, seven of the questions gave participants the opportunity to express their responses in their own words. These seven questions were posed in such a way as to draw out from the respondents how specific problems and solutions are related to the four major needs assessment questions of the Transformation Grant. For example, one question asked participants, "What is working well within the mental health system?" Another asked participants to envision a more positive future: "What would the ideal mental health system look like to you?"

After the researchers reviewed answers to each question, the statements were then divided into broad categories of responses. Two trained and experienced interviewers assigned each response to a corresponding category. The inter-rater reliability was assessed for each question.[4]

For each question, responses were broken out by recovery/non-recovery orientation on the ROSI. The seven ROSI scales identified above were combined into one scale. Respondents who scored in the upper 26th percentile (mostly disagree and strongly disagree; mean > 2.75) on the ROSI were categorized as believing the mental health system has a non-recovery orientation (**the ROSI_NR group**) whereas respondents scoring in the lower 74th percent (mostly agree and strongly agree; mean < 2.75) were categorized as believing the service system has a recovery orientation (**the ROSI_R group**).

[4] A 10 percent random sample was conducted on all the open-ended questions for the May intermediate report (N=480) and on four of the seven questions for the final report (N=633). Inter-rater reliability was consistently high (>90 percent), with an average error rate of 7.9 percent.

QUESTION 1: What two things do you like the most about the mental health services you received?

Staff—Includes references to the counseling and non-counseling members of the agency's team

Management and Access to Medications—Includes any reference to medications and/or prescriptions

Availability of Services—Refers to ease and flexibility of scheduling appointments and convenience of the location of services

Self-Improvement/Treatment and Results—Refers to progress made and results of treatment

Negative Response—Contains negative responses to a positively-phrased question (such as "I don't like anything about the mental health system")

Communication—Includes general comments about listening and caring

Other—Includes other responses that don't fall into the categories listed

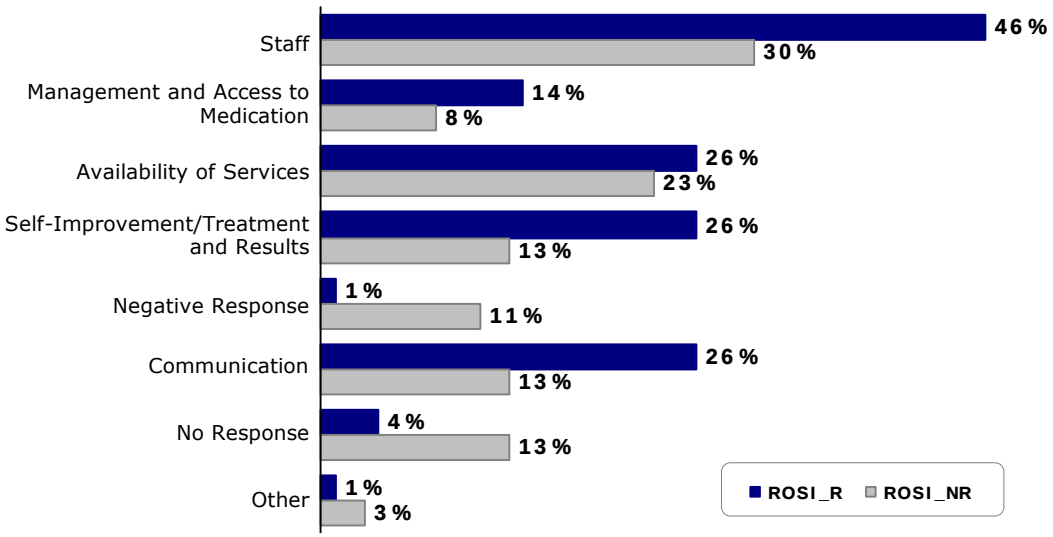
No Response—Respondent did not have a response to the question (field either left blank or respondent simply said 'don't know')

'Nothing'—Refers to the specific response, 'Nothing.' (As this response can be interpreted in several different ways even as a lack of response, a separate category has been created)

FIGURE 19.

Positive comments about services by group

QUESTION: What two things do you like the most about the mental health services you received?



ROSI_R

"I like the fact that they treated me like a real person and there are a lot of options for me."

"I like that if I need to cancel (my appointment) I can get another appointment. My counselor is very helpful with suggestions."

"The expertise and the courtesy."

The most frequent response to the question "What two things do you like the most about the mental health services you received?" was *Staff*.

Respondents who perceived the system as having a non-recovery orientation (i.e., the ROSI_NR group) were much more likely to *Not Respond* (13%), say *"Nothing"* (9%) or reply with a *Negative Response* (11%) to this question than were respondents who perceived the system as being recovery oriented (i.e., the ROSI_R group).

ROSI_NR

"My doctor helps me."

"There is nothing I like about the services I received."

"They give me a place to go every day to be around people."

QUESTION 2: What about the mental health system in your opinion is working well?

Service Availability/Works well—Refers to the existence of an identifiable mental health system, as well as general positive comments such as "works well."

Access to Medication—Includes any reference to medications and/or prescriptions

Staffing—Includes references to the counseling and non-counseling members of the agency's team, including praise for staff members

Support System—Refers to the ability to receive services for crisis management and treatment

Negative Response—Contains negative responses to a positively-phrased question (such as "I don't like anything about the mental health system")

'Nothing'—Refers to the specific response, 'Nothing.'

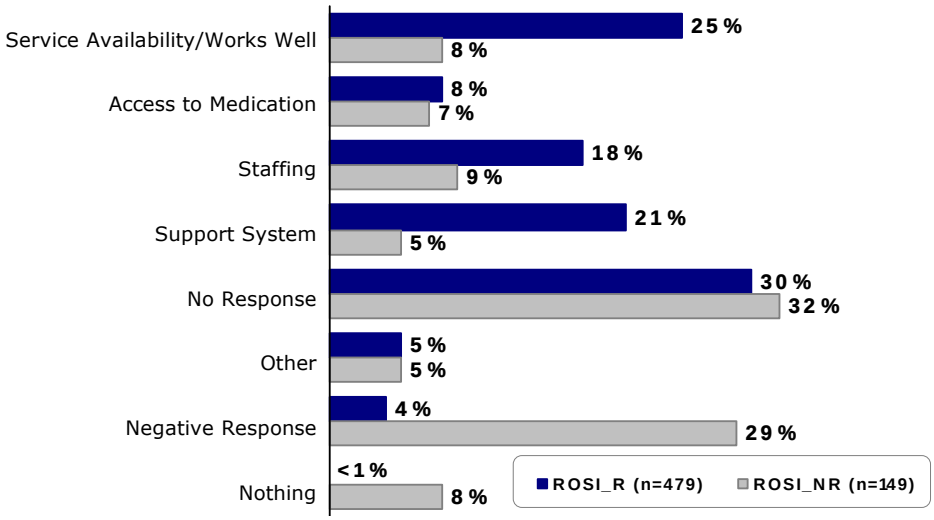
Other—Includes other responses that don't fall into the categories listed

No Response—Respondent did not have a response to the question (field either left blank or respondent simply said 'don't know')

FIGURE 20.

What is working well by group

QUESTION: What about the mental health system in your opinion is working well?



ROSI_R

"I do believe that they are finally beginning to realize that people get better, then they get worse, and then they get better again."

"Getting help to people who need it."

"The staff are very helpful and give a lot of information."

The highest percentage of respondents did not comment on what they thought was working well in the mental health system.

The most common response for participants from the ROSI_NR group was a Negative Response (29%).

The most common response for participants from the ROSI_R group was *Service Availability/ Works Well* (25%).

ROSI_NR

"It's not working well."

"It works for people who are low or no income."

"The crisis line is all that is working well."

QUESTION 3: What two things do you like the LEAST about the mental health services you received?

Access to Services—Includes references to difficulty obtaining services, completing paperwork, and financial issues in paying for services

Staffing/appointments—Refers to staffing issues (e.g., frequently changing staff) and availability and scheduling of appointments

Medications/Treatments—Includes medication and treatment issues for both group therapy and individual therapy

Lack of services/Termination—Refers to respondent experiences with qualifying for and/or becoming ineligible for mental health services

Positive Response—Contains positive responses to a negatively-phrased question (such as "I like everything about the mental health system")

'Nothing'—Refers to the specific response, 'Nothing.' (As this response can be interpreted in several different ways even as a lack of response, a separate category has been created)

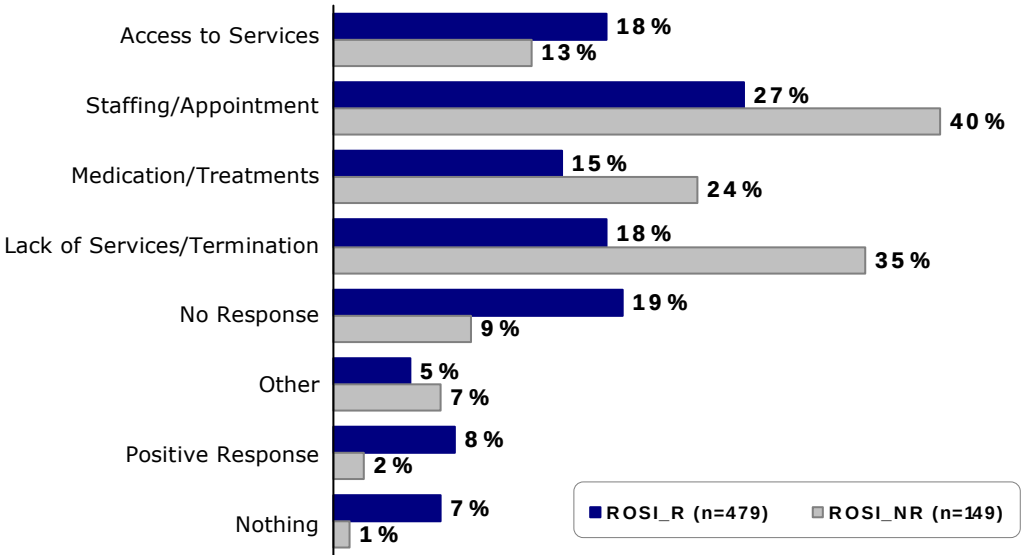
Other—Includes other responses that don't fall into the categories listed

No Response—Respondent did not have a response to the question (field either left blank or respondent simply said 'don't know')

FIGURE 21.

Negative comments about services by group

QUESTION: What two things do you like the least about the mental health services you received?



ROSI_R

"Not giving prior notice that review is coming up and then being kicked off services and having to go through intake all over again."

"The first psychiatrist didn't listen to me. I wasted a year with him. Frustrating."

"It was hard to get in to see a therapist . . . (I) had to wait six weeks."

Staffing/Appointment issues was the most frequently mentioned response when participants were asked what they liked least about the mental health services they received.

Lack of services/Termination (35%) of services was the second most common response from participants in the ROSI_NR group.

ROSI_NR

"The resources are exhausted, high turnover in doctors, revolving door treatment, never see the same doctor twice."

"Services are available but not known (about)."

"That they cut me off medicine that was working extremely well . . . They cut me off too soon."

QUESTION 4: What about the mental health system in your opinion is NOT working well?

Lack of Funding—Refers to the overall lack of funding available for mental health services, and concerns about health insurance

No Follow-up/Lack of support—Includes comments about on-going mental health support and follow-up within the mental health system

Lack of Therapist—Concerns about a lack of properly-trained therapeutic staff, and the high turnover of staff

Medication problems—Refers to medication issues, including concerns about over-medication and under-medication

Bureaucratic issues—Includes references to difficulty accessing services due to large amounts of paperwork required to navigate the mental health system effectively

Positive Response—Contains positive responses to a negatively-phrased question (such as "I like everything about the mental health system")

'Nothing'—Refers to the specific response, 'Nothing.' (As this response can be interpreted in several different ways even as a lack of response, a separate category has been created)

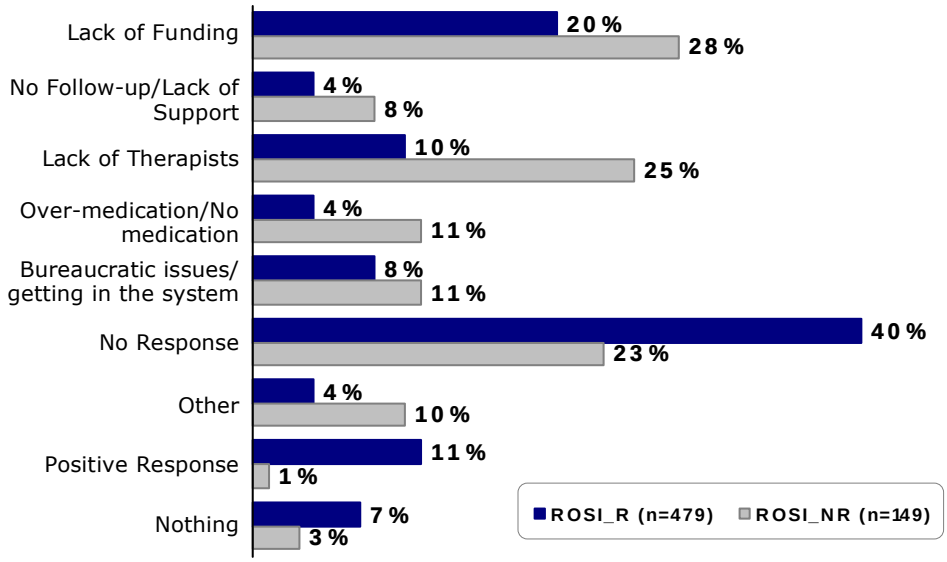
Other—Includes other responses that don't fall into the categories listed

No Response—Respondent did not have a response to the question (field either left blank or respondent simply said 'don't know')

FIGURE 22.

Negative comments about how the system works by group

QUESTION: What about the mental health system in your opinion is NOT working well?



ROSI_R

"Not enough therapists to (too) many patients."

"Programs are being cut. Not enough funding. They closed down a crisis center."

"The distance I have to travel for services."

Lack of Funding (20%) was the most common response of respondents for both the ROSI_NR and ROSI_R groups.

Twenty-five percent of the ROSI_NR group identified *Lack of Therapists* as something that was not working well.

ROSI_NR

"People can't get medical coupons but can't afford it 'out of pocket'."

"Insufficient access to treatment—I had to go through a lot to get in."

"I think the lack of therapists . . . it's hard to get a therapist because they are full and get switch(ed)."

QUESTION 5: If you were giving advice to the mental health decision-makers in Washington State, what TWO things would you tell them that they or staff could do to make your life better?

More money/clinics—Includes references to allocating more money for mental health programs and staff

Access to Programs/Better Treatment—Includes responses regarding improving the availability and quality of mental health treatment, as well as alternative treatments

Family services—Refers to comments about improving family support services for mental health consumers and their families

Transportation/Education/Housing/Employment—Suggestions about how the mental health system could improve access to personal services for mental health consumers

Staffing issues—Includes references to staffing, funding for staff and training, and to lower caseloads within the mental health system

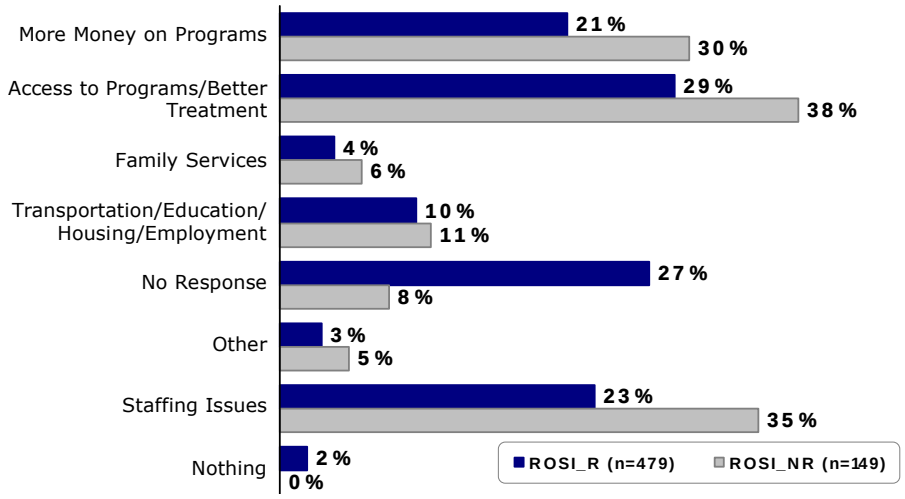
'Nothing'—Refers to the specific response, 'Nothing.' (As this response can be interpreted in several different ways even as a lack of response, a separate category has been created)

Other—Includes other responses that don't fall into the categories listed

No Response—Respondent did not have a response to the question (field either left blank or respondent simply said 'don't know')

FIGURE 23.

Comments about advice to mental health decision-makers by group
QUESTION: If you were giving advice to the mental health decision-makers in Washington State, what TWO things would you tell them that they or staff could do to make your life better?



ROSI_R

"Keep the offices (open) for longer hours and have it open on the weekends."

"Make services available to anyone in need—should be free clinics, like for health services I had were excellent but there was too much turn-over, no consistency for client. Pay staff more to get them to stay."

"More resources for financial (needs) and housing. Transportation needs be met more for people to get to and from appts."

Better *Access to Programs/Better Treatment* was the most common response for both groups when this question was posed.

Staffing issues (e.g., lower caseloads) was the next most common response for the ROSI_NR group (35%).

ROSI_NR

"Continuity of care that has been disrupted by budget cuts, sensitivity training."

"They should have more options for (a client's) family and . . . be able to listen to the person, and listen better."

"More emphasis on peer counseling, consumer advocacy, people who have been thru the system and understand the consumer side . . . too much dependency on drugs, not enough (therapists)."

QUESTION 6: What would the ideal mental health system look like to you?

Accessibility for All—Includes general comments about the ability for anyone to access mental health services when needed

Better Staff/Training—Refers to the need for more staffing with better training

Better Treatment—Comments referring to increased availability of treatment programs, as well as better treatment alternatives

Employment/Other Services—Suggestions about how the mental health system could improve access to personal services for mental health consumers

Insurance/Financial—Refers to increased funding available for mental health services, as well as access to health insurance

Fine as it is—Includes comments from respondents who indicated that they felt the mental health system is working fine as it is right now

Better Communication/Less Stigma—Includes general comments from respondents who wished for better communication and/or less stigma within the mental health system. Also included comments calling for education about mental illness for the general population.

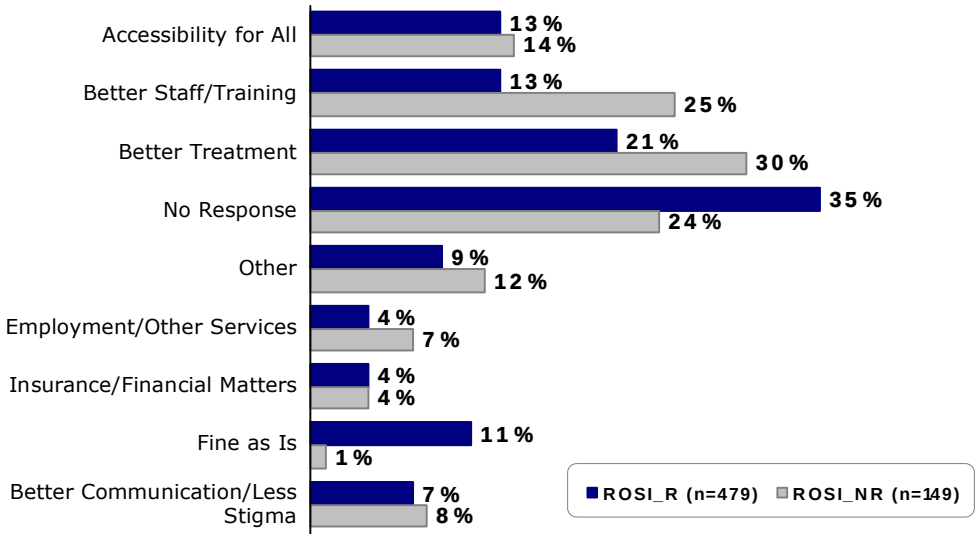
Other—Includes other responses that don't fall into the categories listed

No Response—Respondent did not have a response to the question (field either left blank or respondent simply said 'don't know')

FIGURE 24.

Comments about ideal mental health by group

QUESTION: What would the ideal mental health system look like to you?



ROSI_R

"Primarily, it would be cheaper."

"I would like to see mental health care—to be screened—when we are very young. Starting in kindergarten."

"A system where even consumers can work together to provide mental health treatment."

Better Treatment (30%) was the most common response from both groups.

Better Staff/Training was the second most common response (25%) for the ROSI_NR group; only 13% of the ROSI_R group identified this as part of an ideal mental health system.

ROSI_NR

"More treatment for people with drugs and alcohol (issues), and better housing, more money, and more extensive services."

"Available and free."

"You ought to build more hospitals and fewer jails, because lots of the guys in jail should be in a hospital instead."

QUESTION 7: If the mental health system changed, how would you know it is moving in a positive direction?

Greater Access to services—Refers to comments about the ability of more individuals to access services when needed, as well as improved treatment programs.

Media/word of mouth—Includes comments about changes would be reported in the media (t.v., newspaper, radio) and by surveys, as well as discussed in conversation within society.

Less people on streets/jails—Specific references made to fewer homeless people and fewer people incarcerated.

General Population Temperament—Includes comments about how positive changes in the mental health system would be positively connected to changes in behavior and attitude within the general population

Personal experience—Refers to comments by a respondent that he or she would directly observe changes in the mental health system

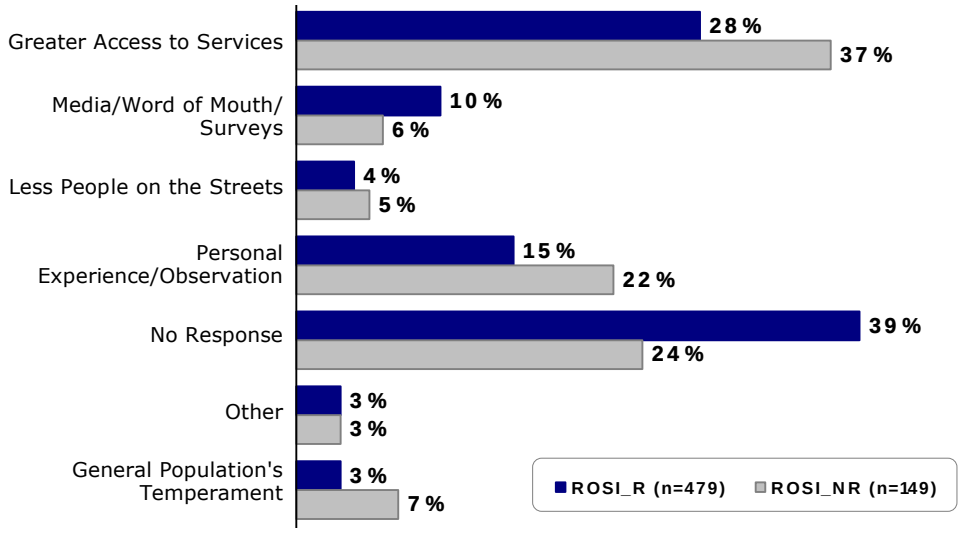
No Response—Respondent did not have a response to the question (field either left blank or respondent simply said 'don't know')

Other—Includes other responses that don't fall into the categories listed

FIGURE 25.

Identifying positive changes by group

QUESTION: If the mental health system changed, how would you know it is moving in a positive direction?



ROSI_R

"(I would) hear it in my NAMI groups, groups, news papers."

"By the number of people getting treatment and showing positive results."

"It doesn't take you so long to get in."

"I would see more on tv about it."

For both groups, the most common response was *Greater Access to Services.*

This was followed by "Personal Experience/Observation."

ROSI_NR

"They should listen to people and provide necessary social services."

"There would be more programs that had proper funding."

"Better communication. Attempting to educate the general population about the services available."

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ATTACHMENT 1: Loadings on Scales Identified in ROSI Report

Person-Centered Decision Making and Choice

	COMPONENT							
	1	2	3	4	5	6	7	8
q31. Staff treat me with respect regarding my cultural background (think of race, ethnicity, religion, language, age, sexual).	.681	.050	.010	-.114	-.008	.098	-.139	.071
q18. Staff believe that I can grow, change and recover.	.673	.301	.018	-.235	.054	.036	.004	-.135
q28. Staff give me complete information in words I understand before I consent to treatment or medication.	.735	.015	.074	-.070	.216	.037	-.072	.105
q32. Staff listen carefully to what I say.	.734	.122	.156	-.123	.166	.091	-.064	-.005
q30. Staff stood up for me to get the services and resources I needed.	.601	.205	.232	.065	.320	.254	-.130	.111
q29. Staff encourage me to do things that are meaningful to me.	.687	.280	.125	-.107	.175	.079	-.061	-.015
q21. Staff see me as an equal partner in my treatment program.	.706	.161	.069	-.091	.105	.158	-.261	.027
q17. I have a say in what happens to me when I am in crisis.	.620	.240	.170	.002	-.093	.064	.088	-.055
q38. The doctor worked with me to get on medications that were most helpful for me.	.525	.093	.358	-.015	.051	.068	-.051	-.022
q42. I have information or guidance to get the services and support I need, both inside and outside my mental health agency.	.349	.279	.405	.036	.472	.105	-.205	.003
q20. Staff use pressure, threats, or force in my treatment.	-.457	.037	-.166	.097	.089	-.135	.484	-.042
q14. I lack the information or resources I need to uphold my client rights and basic human rights.	-.096	-.119	-.248	.570	-.096	-.183	.309	-.071
q12. Mental health services helped me get medical benefits that meet my needs.	.188	.311	.288	.185	.218	.394	-.064	.199
q3. There is at least one person who believes in me.	.210	-.024	.141	-.262	-.107	.625	.120	.204
q27. There are consumers working as paid employees in the mental health agency (service agency) where I receive services.	.149	.074	-.018	-.075	.814	.008	.145	-.016
q37. My treatment plan goals are stated in my own words.	.577	.105	.048	-.206	.360	.007	.110	.278

Invalidated Personhood

q39. I am treated as a psychiatric label rather than as a person.	-.497	-.063	-.066	.298	-.154	.036	.376	-.100
q4. I do not have the support I need to function in the roles I want in my community.	-.107	-.093	-.697	.190	.052	.063	-.004	-.043
q34. Mental health staff interfere with my personal relationships.	-.522	.111	-.186	-.018	-.028	.032	.326	-.063
q7. Staff do not understand my experience as a person with mental health problems.	-.221	-.226	-.282	.601	-.052	-.136	.100	.057

q10. Mental health services have caused me emotional or physical harm.	-.355	-.048	-.317	.277	-.101	-.266	.381	-.129
q8. The mental health staff ignore my physical health.	-.314	.036	-.226	.593	-.120	-.140	.089	-.081
q5. I do not have enough good service options to choose from.	-.070	-.154	-.713	.216	-.049	-.211	.086	-.082
q2. Staff respect me as a whole person.	.399	.100	.135	-.141	-.115	.585	-.182	.072
q13. Mental health services led me to be more dependent, not independent.	-.033	.007	-.003	.701	.086	.037	.052	-.067
Self-Care and Wellness								
q41. My family gets the education or supports they need to be helpful to me.	.314	.286	.276	.147	.423	.040	-.202	.069
q22. Mental health staff support my self-care or wellness.	.718	.262	.089	-.169	.160	.100	-.117	-.016
q35. Mental health staff help me build on my strengths.	.630	.384	.095	-.111	.179	.114	-.111	.040
q36. My right to refuse treatment is respected.	.740	-.017	.112	.015	-.034	.141	.000	.182
q40. I can see a therapist when I need to.	.376	.230	.411	.009	.316	.094	-.218	.005
Basic Life Resources								
q25. I have reliable transportation to get where I need to go.	.153	.299	.399	.011	.066	-.305	.058	.119
q19. I have housing that I can afford.	.119	.484	.065	.046	.017	-.186	-.221	.539
q15. I have enough income to live on.	.116	.675	.097	.036	.011	-.136	-.082	.245
q9. I have a place to live that feels like a comfortable home to me.	.045	.081	.126	-.140	-.013	.155	.029	.752
q6. Mental health services helped me get housing in a place I feel safe.	.136	.448	.087	-.079	.301	.285	-.147	.398
Meaningful Activities								
q23. Mental health services helped me get or keep employment.	.125	.644	.172	-.061	.190	.155	-.031	.058
q24. I have a chance to advance my education if I want to.	.331	.455	.267	-.153	-.031	.050	.052	-.040
q1. I am encouraged to use consumer-run programs (for example: support groups, drop-in centers, etc.).	.105	.134	-.032	-.007	.368	.611	-.045	-.082
q16. Services help me develop the skills I need.	.247	.637	.136	-.187	.107	.287	-.083	-.123
Peer Advocacy								
q26. There was a consumer peer advocate to turn to when I needed one.	.252	.377	.376	-.068	.329	.066	-.023	.100
Staff Treatment Knowledge								
q33. Staff lack up-to-date knowledge on the most effective treatments.	-.125	-.191	-.012	.239	.055	.011	.699	.008
Access								
q11. I cannot get the services I need when I need them.	-.266	-.171	-.575	.226	-.119	-.234	.188	-.103

ATTACHMENT 2: Rotated Component Matrix(a) ROSI 42-Item Scale

	COMPONENT 1	2	3	4	5	6	7	8
Staff and Treatment Satisfaction Scale								
q36. My right to refuse treatment is respected.	.740	-.017	.112	.015	-.034	.141	.000	.182
q28. Staff give me complete information in words I understand before I consent to treatment or medication.	.735	.015	.074	-.070	.216	.037	-.072	.105
q32. Staff listen carefully to what I say.	.734	.122	.156	-.123	.166	.091	-.064	-.005
q22. Mental health staff support my self-care or wellness.	.718	.262	.089	-.169	.160	.100	-.117	-.016
q21. Staff see me as an equal partner in my treatment program.	.706	.161	.069	-.091	.105	.158	-.261	.027
q29. Staff encourage me to do things that are meaningful to me.	.687	.280	.125	-.107	.175	.079	-.061	-.015
q31. Staff treat me with respect regarding my cultural background (think of race, ethnicity, religion, language, age, sexual	.681	.050	.010	-.114	-.008	.098	-.139	.071
q18. Staff believe that I can grow, change and recover.	.673	.301	.018	-.235	.054	.036	.004	-.135
q35. Mental health staff help me build on my strengths.	.630	.384	.095	-.111	.179	.114	-.111	.040
q17. I have a say in what happens to me when I am in crisis.	.620	.240	.170	.002	-.093	.064	.088	-.055
q30. Staff stood up for me to get the services and resources I needed.	.601	.205	.232	.065	.320	.254	-.130	.111
q37. My treatment plan goals are stated in my own words.	.577	.105	.048	-.206	.360	.007	.110	.278
q38. The doctor worked with me to get on medications that were most helpful for me.	.525	.093	.358	-.015	.051	.068	-.051	-.022
q34. Mental health staff interfere with my personal relationships.	-.522	.111	-.186	-.018	-.028	.032	.326	-.063
q39. I am treated as a psychiatric label rather than as a person.	-.497	-.063	-.066	.298	-.154	.036	.376	-.100
Independence Scale								
q15. I have enough income to live on.	.116	.675	.097	.036	.011	-.136	-.082	.245
q23. Mental health services helped me get or keep employment.	.125	.644	.172	-.061	.190	.155	-.031	.058
q16. Services help me develop the skills I need.	.247	.637	.136	-.187	.107	.287	-.083	-.123
q24. I have a chance to advance my education if I want to.	.331	.455	.267	-.153	-.031	.050	.052	-.040
q6. Mental health services helped me get housing in a place I feel safe.	.136	.448	.087	-.079	.301	.285	-.147	.398
q26. There was a consumer peer advocate to turn to when I needed one.	.252	.377	.376	-.068	.329	.066	-.023	.100
Access Scale								
q5. I do not have enough good service options to choose from.	-.070	-.154	-.713	.216	-.049	-.211	.086	-.082
q4. I do not have the support I need to function in the roles I want in my community.	-.107	-.093	-.697	.190	.052	.063	-.004	-.043
q11. I cannot get the services I need when I need them.	-.266	-.171	-.575	.226	-.119	-.234	.188	-.103
q40. I can see a therapist when I need to.	.376	.230	.411	.009	.316	.094	-.218	.005
q25. I have reliable transportation to get where I need to go.	.153	.299	.399	.011	.066	-.305	.058	.119

Invalidated Personhood Scale								
q13. Mental health services led me to be more dependent, not independent.	-.033	.007	-.003	.701	.086	.037	.052	-.067
q7. Staff do not understand my experience as a person with mental health problems.	-.221	-.226	-.282	.601	-.052	-.136	.100	.057
q8. The mental health staff ignore my physical health.	-.314	.036	-.226	.593	-.120	-.140	.089	-.081
q14. I lack the information or resources I need to uphold my client rights and basic human rights.	-.096	-.119	-.248	.570	-.096	-.183	.309	-.071
Supports Scale								
q27. There are consumers working as paid employees in the mental health agency (service agency) where I receive services.	.149	.074	-.018	-.075	.814	.008	.145	-.016
q42. I have information or guidance to get the services and support I need, both inside and outside my mental health agency	.349	.279	.405	.036	.472	.105	-.205	.003
q41. My family gets the education or supports they need to be helpful to me.	.314	.286	.276	.147	.423	.040	-.202	.069
Encouragement Scale								
q3. There is at least one person who believes in me.	.210	-.024	.141	-.262	-.107	.625	.120	.204
q1. I am encouraged to use consumer-run programs (for example: support groups, drop-in centers, etc.).	.105	.134	-.032	-.007	.368	.611	-.045	-.082
q2. Staff respect me as a whole person.	.399	.100	.135	-.141	-.115	.585	-.182	.072
q12. Mental health services helped me get medical benefits that meet my needs.	.188	.311	.288	.185	.218	.394	-.064	.199
Negative Service Experience Scale								
q33. Staff lack up-to-date knowledge on the most effective treatments.	-.125	-.191	-.012	.239	.055	.011	.699	.008
q20. Staff use pressure, threats, or force in my treatment.	-.457	.037	-.166	.097	.089	-.135	.484	-.042
q10. Mental health services have caused me emotional or physical harm.	-.355	-.048	-.317	.277	-.101	-.266	.381	-.129
Adequate Housing Scale								
q9. I have a place to live that feels like a comfortable home to me.	.045	.081	.126	-.140	-.013	.155	.029	.752
q19. I have housing that I can afford.	.119	.484	.065	.046	.017	-.186	-.221	.539

Extraction Method: Principal Component Analysis.
Rotation Method: Varimax with Kaiser Normalization.
a Rotation converged in 11 iterations

Chapter 5 | **The Mental Health Specialists**

AUGUST 2006

PRELIMINARY | Still Under Review

THE MENTAL HEALTH DIVISION, THE REGIONAL SUPPORT NETWORKS, AND THE PROVIDERS SPEAK

By DSHS Research and Data Analysis Division

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ABSTRACT

The DSHS Mental Health Division (MHD) and the Regional Support Networks (RSNs) are charged by state and federal law to serve the most severely, chronically and acutely mentally ill persons in Washington. Emergency care, crisis care and psychiatric hospitalization are available to everyone; community care is limited by funding and eligibility rules. Access can be difficult for homeless persons, youth and families, persons with limited English proficiency, and people in rural areas and small towns.

Over time, the MHD-RSN system has become over-focused on acute care, and is not doing enough either with "recovery" services involving jobs, housing and education, or with early intervention. Children and families are particularly underserved. Though the Division is involved in several integrated care projects, integration of mental health services with other chronic care issues is still problematic.

More than half of the Regional Support Networks (RSNs) and many local providers are, through local leadership and planning, initiating practices that will support transformation. However:

- The mix of state and federal eligibility restrictions, benefit designs, and organizational silos limit what local areas can do.
- Many consumers who need mental health services cannot be served at all under current state rules.
- Many consumers cannot be served until they are in crisis and there is little or no capacity to fund early intervention or even treat serious problems when they first arise.

Collectively the Washington State mental health specialists recommend the following:

- Change state laws restricting eligibility; make service provision more seamless.
- Make medical benefit designs less restrictive.
- Develop and fund integrated children's mental health.
- Focus on integrated and coordinated services for those with multiple problems.
- Focus on assessing and treating mental health disorders when they first arise.
- Integrate consumers and families into both policy and services.

Introduction and Context

The DSHS Mental Health Division and the Regional Support Networks fund and administer about two-thirds of the dollars spent on mental health services to low-income Washington consumers—over half a billion dollars per year. They serve about 130,000 people per year—about half of the low-income people estimated to have psychiatric disorders causing moderate to severe functional limitations. (See Chapter 2 for definitions of these terms and estimates). Unlike the other agencies discussed in Chapter 6, all their clients are mental health consumers by definition!

Organizationally, the Mental Health Division is part of the umbrella human service agency—the Department of Social and Health Services (DSHS). Since 2005, the MHD has been part of the newly constituted DSHS Health and Recovery Services Administration. This restructuring brought all Medicaid responsibilities, and the Divisions of Mental Health and Alcohol and Substance Abuse, under one administrative wing.

This movement was explicitly transformative. It was intended to blend three formerly more separate organizations into one more blended administration. A consultant's report which recommended this change, says: *"the re-alignment … will require a cultural shift from independent 'silos' to more interdependent operations. This restructuring will… offer the opportunity to address administrative inefficiencies and develop policy and integrated treatment approaches for physical, mental health and substance abuse disorders"* (Mercer Report, pages 3-5).

Under this new administrative structure, the Mental Health Division still has primary responsibility for serving the severely, chronically and acutely mentally ill. It operates three fully accredited and certified state psychiatric hospitals, two for adults and one serving children. Community services for the severely mentally ill are managed through the regional administrative structure created in the 1989—the fourteen Regional Support Networks, which are made up of one or more contiguous counties. The Mental Health Division is the purchaser of services through Regional Support Networks (RSNs) for the public mental health system on behalf of people covered by Medicaid and other vulnerable populations.[1] The RSNs then contract with local mental health agencies to provide direct mental health services to the consumers.

There have been several changes in the relationship between the MHD and the RSNs, mainly designed to incorporate managed care principles, since the law was enacted in 1989. At present it works as follows: the Washington State MHD purchases outpatient mental health services through capitated payments to the RSNs, and the RSNs operate Prepaid Inpatient Health Plans (PIHPs) by assuming the financial risk to provide all medically necessary outpatient and inpatient community mental health rehabilitation services to severely, acutely and chronically mentally ill people in their geographic region[2].

Some of the inpatient services are provided through allocated shares in the beds at the state-supported mental hospitals. When an RSN exceeds its allotted beds, it is financially responsible for the additional bed days at the state hospitals. The exact way this arrangement works has changed several times, and is still changing.

Minimum sets of community services for two "levels of care" need are specified in the contracts between the RSNs and the MHD. RSNs are obligated to provide these services to all the Medicaid consumers who meet the care standards, and to as many as possible within allotted resources of the non-Medicaid consumers who meet those standards. Each RSN can decide how intense those services are and how to integrate and coordinate with other local agencies.

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[1] Ibid. *Managed Care in the Public Mental Health System: The Washington Approach*. The role of the RSNs was covered comprehensively in this 1998 document—most of the RSN discussion of roles in this discussion paraphrases this document. Current conversations with MHD authorities note that RSN roles and underlying statutory authority accurately reflect current circumstances.

[2] Title XIX of the Social Security Act is administered by the Centers for Medicare and Medicaid Services.
Title XIX appears in the United States Code as §§1396-1396v, subchapter XIX, chapter 7, Title 42.
Regulations relating to Title XIX are contained in chapter IV, Title 42, and subtitle A, Title 45, Code of Federal Regulations. This is cited at: http://www.ssa.gov/OP_Home/ssact/title19/1900.htm

State Policy from Prior System Changes

Washington State has worked to transform its mental health system before, and the legislative intent as embodied in that legislation has a familiar ring.

In 1989, Senate Bill 5400 created the Regional Support Networks and, in the published information, *"launched a new era of mental health reform."* The "*intent of the legislation was to address concerns of citizens, consumers, mental health advocates, and counties*." Among the issues to be addressed were "*consumer and family access to care, equitable access to resources of the state psychiatric hospitals, moving the resources and distribution of resources closer to the people concern and addressing the perceived inequities of services on the Eastern side of the state as compared with those on the Western side of the state*. "

The enabling law. Chapter 71.24 RCW, the Community mental health services act[3], was written was unambiguous in its intent. It spoke to recovery and resiliency before such concepts became national by-words, and to the special needs of underserved populations: "*including minorities, children, the elderly, disabled, and low-income persons*." It is clear that access to mental health services should not be limited by "*person's history of confinement in a state, federal, or local correctional facility*."

The Community Mental Health Services Act promoted early identification and prevention, citing "*the early identification of mentally ill children and* (the need) *to ensure that they receive the mental health care and treatment which is appropriate to their developmental level."*

The law was specific and targeted as to areas of need and functioning which should be taken into account in order to accomplish these goals: "*This care should improve home, school, and community functioning, maintain children in a safe and nurturing home environment, and should enable treatment decisions to be made in response to clinical needs in accordance with sound professional judgment while also recognizing parents' rights to participate in treatment decisions for their children*."

Further, RCW 71.24 called for inclusion of consumers and families in important decision-making: "*The involvement of persons with mental illness, their family members, and advocates in designing and implementing mental health services that reduce unnecessary hospitalization and incarceration and promote the recovery and employment of persons with mental illness. To improve the quality of services available and promote the rehabilitation, recovery, and reintegration of persons with mental illness, consumer and advocate participation in mental health services is an integral part of the community mental health system and shall be supported."*

As well, the law was unambiguous in its call for DSHS and other agencies with responsibilities for the needs of citizens to work cooperatively across existing eligibility and funding silos to deliver adequate and competent services to the citizens of Washington State: "*Coordination of services within the department, including those divisions within the department that provide services to children, between the department and the office of the superintendent of public instruction, and among state mental hospitals, county authorities, regional support networks, community mental health services, and other support services, which shall to the maximum extent feasible also include the families of the mentally ill, and other service providers and coordination of services aimed at reducing duplication in service delivery and promoting complementary services among all entities that provide mental health services to adults and children*."

It has been 18 years since this law was passed. These issues remain current; many of them still need to be addressed in this transformation.

[3] Chapter 71.24 RW Community Mental Health Services Act can be found at: http://apps.leg.wa.gov/RCW/default.aspx?cite=71.24

Regional Support Networks and Transformation

In the RSN interviews, we asked them to tell us what is working well in their region, from their perspective. Those interview notes were subsequently content-analyzed and coded to see whether they involved "transformative" activities such as inclusion of consumer voice, work on recovery issues, service coordination and integration, innovative technology, and evidence-based practices.

From those notes, we found:

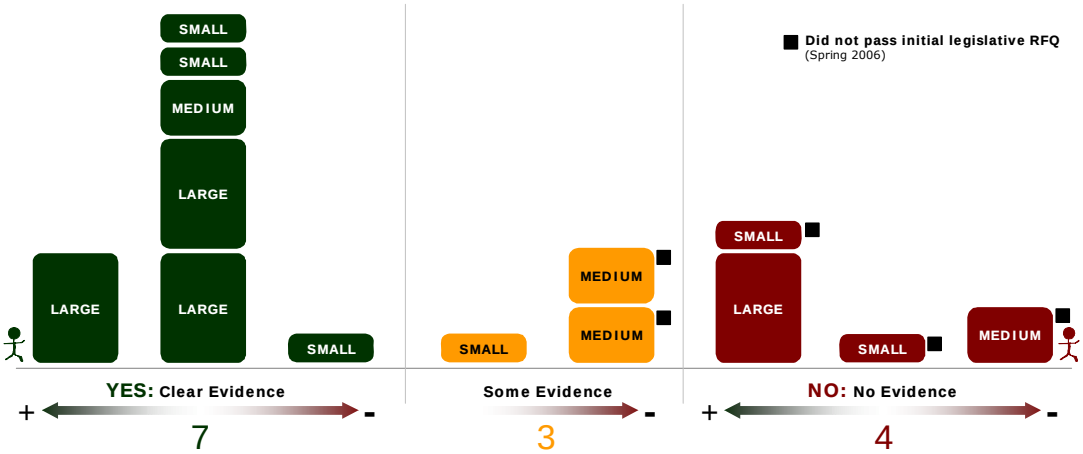
- There is clear evidence that half of the RSNS (7 out of 14) are driving program and counseling activities through transformative goals. While these regions represent half the RSNs, they represent two-thirds of the state's MHD consumers.
- For three RSNs, there is some evidence of transformation, but that transformation is either partial or contradictory. These three RSNs comprise 16 percent of the MHD consumers.
- For the remaining four RSNS, there is no evidence of transformation. They serve 21 percent of the MHD consumers.

It is interesting to note that the five RSNs that did not "pass" the legislatively required RFQ this spring were all included in the "some or no transformative evidence" groups. These regional networks may really be struggling simply to survive.

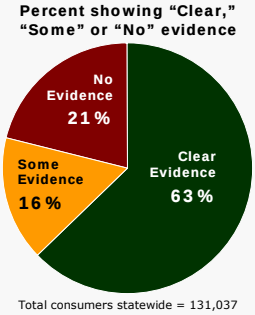
RSNs tell us WHAT WORKS from their perspective

We analyzed whether "Transformational Goals" are driving program and counseling-based activities in the Regional Support Networks

Boxes indicate relative population size of the RSNs reported to use – or not use – Transformation Goals to drive program and counseling-based activities



RSN		Population	Number Served
4	LARGE	500,000 – 1,800,000	15,000 – 35,000
4	MEDIUM	250,000 – 499,000	5,000 – 14,999
6	SMALL	50,000 – 249,000	1,500 – 4,999



Mental Health Providers and Transformation

This view of the mental health providers which are licensed to provide services to those eligible mentally ill persons in Washington State is based upon interviews and data obtained from the Washington Community Mental Health Council (WCMHC).

WCMHC is a non-profit, professional association with 41 member mental health centers in communities across the State of Washington. Typically, these centers are large comprehensive centers which, combined, serve 75 to 85 percent of the persons receiving publicly funded mental health care in the state.

Policies. Mental health providers in Washington State must be licensed to practice under the rules of *WAC 388-865-0400: Community support service providers*.

> WAC 388-865-0400 states: The mental health division licenses and certifies community support service providers. To gain and maintain licensure or certification, a provider must meet applicable local, state and federal statutes and regulations as well as the requirements of WAC 388-865-400 [388-865-0400] through 388-865-450 [388-865-0450] as applicable to services offered. The license or certificate lists service components the provider is authorized to provide to publicly funded consumers and must be prominently posted in the provider reception area. In addition, the provider must meet minimum standards of the specific service components for which licensure is being sought.

Training. WCMHC did a detailed survey of its member agencies and found the following information about which Evidence-based Practices (EBP) were being offered across the surveyed members.

The results are as follows in rank order of number of agencies practicing these EBPs:

Evidence-Based Practice	Number of Agencies
Wraparound—Strength-based approach where comprehensive services are 'wrapped-around' children and families with exceptional needs.	**26** agencies
Parent Training—Provides parent of exceptional need children with behavior management skills	**26** agencies
Medication Management—Training in using medication in a systematic and effective way	**25** agencies
Elderly Depression Screening and Treatment—Xxxx	**21** agencies
Integrated Co-Occurring Disorders—Offering mental health and substance abuse services in one setting at the same time	**19** agencies
Multisystemic Therapy—Integrated family and community based treatment for juvenile offenders with multiple diagnoses	**18** agencies
Dialectic Behavior Therapy (DBT)—Combination of therapies based on cognitive behavioral therapy for persons with emotion regulation difficulties	**18** agencies
Supported employment—Xxxx	**17** agencies
Assertive Community Therapy (ACT)—Multidisciplinary psychiatric treatment in their homes, on the job, and in social settings 24/7 365 days/year	**15** agencies
Family Psychoeducation—Group intervention for SPMI patients	**15** agencies
Illness Management and Recovery—Behavioral interventions in a weekly treatment	**12** agencies
Functional Family Therapy—Used to treat high-risk youth, often juvenile offenders	**10** agencies
Treatment Foster Care—Foster parents trained to assume role of primary interventionists	**7** agencies

The WIMRT also offers training to providers—in fact, part of their mandate has been to initiate and sustain training in support of those who provide services to mentally ill persons across the state. Training they provide can be found at their joint website: http://depts.washington.edu/washinst/

Summary of Key Services, Issues and Gaps

In the rest of this chapter, we present comments, data, and analysis about the current system which came from interviews with persons from three different "positions" within the mental health system.

We interviewed:

- The Mental Health Division Director and his key staff
- The Directors of each of the 14 regional support network (RSNs)
- A group of mental health providers

In these interviews there were some issues that came up frequently. These issues are summarized in the chart below. The rest of this chapter addresses each issue, and briefly describes the policies, practices, training, budgets, and services associated with that issue. Provider, RSN and MHD voices are "blended" in each section. However, the provider interviews are also summarized separately at the end of the chapter.

	Washington State Needs Assessment		
	Gaps by Perspectives		
Washington State Gap Areas Organized Under the President's New Freedom Commission on Mental Health Goals	**MHD**	**RSNS**	**PROVIDERS**
GOAL 1: Mental Health is Essential to Overall Health			
• Access to services	✓	✓	✓
• Stigma and public knowledge	✓	✓	
GOAL 2: Mental Health is Consumer and Family Driven			
• Service choice and quality	✓	✓	✓
• Jobs, school, and housing help	✓	✓	✓
• Consumer Voice	✓	✓	
• Service integration and coordination	✓	✓	✓
GOAL 3: Disparities in Mental Health Services are Eliminated			
• Access to services in rural areas		✓	✓
GOAL 4: Early Mental Health Screening, Assessment and Referral are Common Practices			
• Early intervention and screening	✓	✓	
• School and primary care collaboration	✓	✓	
GOAL 5: Excellent Mental Health Care is Delivered and Research is Accelerated			
• Service quality and incentives	✓	✓	✓
GOAL 6: Technology is Used to Access Mental Health Care and Information			
• Integrated health records	✓	✓	✓

Access to Services

"Scads of people are turned away because they aren't Medicaid eligible. ***This is wrong****."* (RSN director)

"Funding streams for mental health are restrictive and lack flexibility needed to respond to individualized needs…resulting in a CMS/Medicaid-defined system of priorities and care rather than a state-directed, recovery-oriented system of care." (Mental health provider)

"Access to care standards are extremely confusing and limiting. The system does not provide a 'door' to treatment, but a maze." (Rural RSN Director)

"Access to Care standards—how people come in the front door is flawed. The door is too narrow for all the need." (Urban RSN Director)

The Mental Health Division and the RSNs are responsible to serve different populations at different levels of service, depending on the level of functioning and seriousness of mental illness and on the funding.

"Crisis response, disaster response services, and involuntary treatment services are available to all state residents. If a state resident is covered by Medicaid, medically necessary mental health services including case management, hospitalization, brief therapy, and community support must be provided. ***Other people with serious mental illness are to be provided services as resources allow*** *(emphasis added)."*[4]

The result of the lidded resources is clear:

"There are a significant number of county citizens that can't be served by RSN because they are not Medicaid eligible. RSN is using state-only dollars on mandated services, can't use for treatment." (Urban RSN Director)

Receiving community outpatient care from the Mental Health Division and the regional support networks depends on having some combinations of the following characteristics. These are called "access to care" standards.

- **Having one of the "right" diagnoses.** These are generally limited to psychotic disorders, bipolar 1 and 2, specified depression and anxiety, although other conditions are possible if the debility they cause is severe. This eliminates consumers whose lives are moderately affected by other treatable psychiatric disorders such as phobias, dementias, borderline personality, dysthemia, and obsessive-compulsive disorder.
- **Having moderate to severe functional limitations caused by the psychiatric condition.** This makes it difficult to treat conditions early in the person's life, since the functional problems have not yet occurred. It also focuses on the "deep end" client even later in life, since the person cannot be treated if they are still functioning.
- **Being insured through Medicaid or for some other DSHS funded medical plans.** This condition eliminates most working-age adults without dependent children, unless they are defined as "disabled" by receiving SSI benefits, or presumptively disabled by receiving GA-X benefits. Adults receiving GA-U or ADATSA cannot be served with Medicaid funds; they must be served with lidded state-only funding even if their conditions are more severe than the Medicaid-funded consumers who are being served.
- **Having a recent psychiatric hospitalization.** This can "trump" the other conditions for a year. It is difficult to hospitalize consumers in Washington State without their consent, unless they are actively dangerous to themselves or other people as a result of their condition.

[4] Managed Care in the Public Mental Health System: The Washington Approach (MHD:1998).

A consumer whose functional debility is moderate (between 50 and 60 on a GAF or CGAS scale) is not entitled to much individual treatment through the RSNs. Through the RSN contract with the MHD, those "Level 1" consumers are only entitled to brief therapy, group therapy, psycho-education and medication management. So even with the "right" diagnosis (e.g. schizophrenia) and the "right funding" (Medicaid), individual counseling is hard to obtain until the debility is severe (GAF or CGAS goes below 50).

There is another service option for low-income persons who have a mental illness that does not meet MHD/RSN "access to care" standards, if those consumers are covered by health plans funded by Medicaid or by the Basic Health Plan administered by the Health Care Authority. Those plans include limited mental health benefits—generally twelve outpatient visits a year and unlimited medication management—in the general medical or psychiatric specialty sector. However, the limitations on payment, particularly for psychiatric care under Medicaid, have resulted in difficulties in actually obtaining care for which consumers are theoretically eligible. *"It is a real problem for providers to maintain psychiatric presence – need prescribers of medication."* (RSN Director)

DSHS consumers whose medical care is based on General Assistance Unemployable or ADATSA coverage have another problem. Their medical benefits do not allow any mental health counseling at all, although they do include medication management. If they meet RSN "diagnostic" standards they can be served by the RSNs as long as the limited "state-only" funding dollars are available. But these people—some who have been declared by the state as unable to work due to their mental health conditions—cannot receive any counseling or evaluation through their medical coverage.

Some of the working poor may receive mental health benefits through their employer-provided coverage. And another large group of consumers is not entitled to any state care—those who are mentally ill but are not covered through state-only or Medicaid health insurance, and who have no employer-provided insurance. Unless and until these consumers become severe enough to require hospitalization or crisis care from the Mental Health Division and the RSNs, they receive no state-funded mental health treatment. If they receive any care, it is from community and free clinics, religious centers, or individual providers.

An eligibility system this complex is inefficient. RSNs said it took between two and three hours to complete required federal and state paperwork for an intake.

"It takes three hours to do an intake and fill out state paperwork." (Rural RSN Director)

"Takes 2 to 3 hours to complete required federal and state paperwork for an intake." (Urban RSN Director)

"There is too much paperwork. Need to reduce paperwork by at least 50 percent immediately. Right now there is up to 3 hours of paperwork just to enroll person. Immense amount of duplication which is passed form feds to MHD to RSNs to providers to clients." (Rural RSN Director)

Given all these eligibility rules and policies and the time it takes to process them, it is not surprising that the Mental Health Division and the RSNs serve only about half of the low-income persons conservatively estimated to have psychiatric disorders resulting in moderate to severe functional limitations. For the RSNs and providers, this situation presents acutely frustrating ethical dilemmas daily.

"Financial eligibility standards need to be re-visited. How do you serve those not Medicaid eligible? For example: Children with autism can only be seen with state-only dollars." (Urban RSN Director)

"We have a two-tiered system. We have to turn people away without treatment because we cannot use money that we have saved through efficiencies. ***It is a financial and moral disaster."*** *(*RSN director)

Stigma and Public Knowledge

"We have stigma issues. It is a problem for people to be seen going to Mental Health providers. People who can afford it all go to private providers" (Rural RSN director)

"MH Transformation should provide training plus monies to do statewide campaign for de-stigmatization of mental illness" (Rural RSN Director)

"Several consumers already trained can't find work. Need work on de-stigmatization on community and with providers." (Rural RSN Director)

"A transformed system would address stigma around mental illness, which reduces consumer opportunities for involvement in their communities." (Urban RSN Director)

Little is happening in the way of stigma reduction or public perception at either the RSN or the MHD level. Training to consumers and their families is available and is covered under the section on consumer voice.

Service Choice and Incentives

The access rules make clear the fact that the system of care in Washington State is heavily weighted towards the "deep end" consumer. What sorts of services are being purchased for those consumers?

Psychiatric Hospitalization

*"The state is in the acute care business. We are over-burdened with acute inpatient care." (*Mental Health Division)

First and foremost, the Mental Health Division is funding psychiatric hospitalization in the state hospitals. The Mental Health Division operates three fully accredited and certified state psychiatric hospitals, two for adults and one serving children. Western State Hospital, located in Steilacoom, has a total of 984 beds (including the 120 beds at Program for Adaptive Living Center (PALS) and Eastern State Hospital, in Medical Lake (Eastern Washington), has 312 beds. Child Study and Treatment Center is located on the grounds of Western State Hospital has 47 beds.

In the MHD/RSN budget, half the money goes to psychiatric inpatient services either in the state hospitals or community hospitals.

Future Plans. In the upcoming biennium, money has been allocated to increase the bed capacity of both state hospitals. There are five new wards projected at state hospitals from 2006-2207 (four at Western State Hospital and one at Eastern State Hospital). Current planning documents show one ward opening at Eastern State hospital and two at Western state Hospital by June 2006. In September 2006 a third ward will be opened at WSH and the final and fourth ward will be opened at WSH by January 2007. Each ward is 30 persons—so statewide this will add 150 beds to the funded hospital capacity.

However, the MHD also requested and received $30 million to go to RSNs to create PACT Teams (for diversion and transition of persons out of hospitals) and to create other innovative services which would be directly linked to diverting or getting difficult persons out of hospital population. Beginning in April 2007, the first of the PACT Teams will begin training and it is hypothesized that the effect of these PACT teams (east and west) will result in the closure of these added wards by October 2009, from the resulting placement of persons in the community.

*"We're going to have eight full PACT teams (assertive community treatment teams to serve clients with chronic mental health disorders) and some half teams in rural areas by April 2007—this is right in line with evidence-based practices." (*Mental Health Division)

Financial Incentives. The current relationship between the RSNs and the MHD contains some financial "incentive arrows" which over time have tended to increase usage of the state hospitals. The hospital budgets are 'carved out' of managed care. Hospital care (when it is available) is 'free' in the sense that up to the allocated bed amount for each RSN, there is nothing taken from the RSN budget to pay for these beds. And the RSNs have no financial incentive to shop for hospital "diversionary" care for their clients, since they do not receive any of the savings such care might produce.

"The use of state hospital beds is more or less a freebie for the RSNs up to their respective bed allocations." (Mental Health Division)

There have been current statutory and policy changes about how RSN are assigned hospital beds allotments. A suit by Pierce RSN changed the method of assessing liquidated damages. The RSN contracts used to specify a ceiling on hospital census. Each RSN had so many bed allotments at ESH or WSH, but total damages were not assessed unless the total hospital census went above limits. Thus, one RSN could be way over its allotment, but if the total census was below limits, it didn't matter. Only if the total census went up, would an RSN be assessed damages (e.g. a 'fine' per number of bed days over their allotment). In the Pierce RSN settlement, all of the liquidated damages go back to RSNs. However, there is still some discussion about how about how far back in time this agreement reaches. The RSNs get half of the liquidated damages and the MHD gets the other half to distribute to RSNs who are under their allotment as an incentive.

Current legislation required the RSNs to get together—East and West—and determine bed allotment numbers for each RSN. The West side ha s completed its deliberations and has agreed upon allotments; the East side allotments are still under discussion. Each RSN has a contract, and will pay if they go over their individual allotment, regardless of the hospital census total. Each RSN is required by contract to provide 85 percent of all short term (72 hour and 14 day commitments) in community hospitals. This proportion was raised to 90 percent in the 2006 session. The state must provide for 100 percent of all long-term commitments.

Community Services

The core duty of the Regional Support Network is to develop and implement a seamless system of mental health services which meets the individual needs of the severe, chronic and acute consumers within its local geographic area. This range of services must include both hospital and outpatient care for any person who is eligible for publicly funded treatment, when that person's level of need reaches the criteria for medical necessity as defined, and for others whose level of care needs are acute.

To accomplish this service mandate, the RSNs carry out the coordination and purchasing of services, contracting with the Mental Health Division and the service providers. These community services are funded through a two part formula:

- Medicaid funding is distributed through the actuarially derived PIHP rates times the Medicaid eligibles for each RSN.
- State-only money is distributed proportional to the general population within each RSN.

With that funding came broad administrative and statutory authority to develop and maintain the mental health system within their boundaries. They operate administratively under the auspices of WAC 388-865-0200:

> *The mental health division contracts with certified regional support networks to administer all mental health services activities or programs within their jurisdiction using available resources. The regional support network must ensure services are responsive in an age and culturally competent manner to the mental health needs of its community. To gain and maintain certification, the regional support network must comply with all applicable federal, state and local laws and regulations, and all of the minimum standards of this section.*

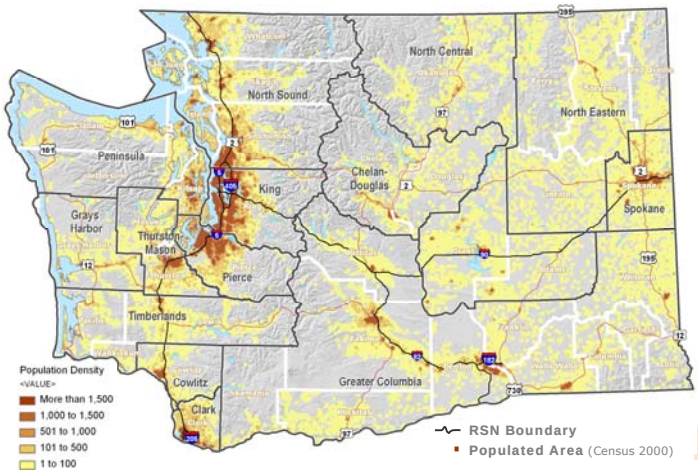
They operate under statute as well—RCW 71.24.045 (Regional support network powers and duties). Among the duties embodied in this law are:

- Contract as needed with licensed service providers.
- Monitor and perform biennial fiscal audits of licensed service providers who have contracted with the regional support network to provide services required by this chapter.
- Assure that the special needs of minorities, the elderly, disabled, children, and low-income persons are met within the priorities established in this chapter.
- Maintain patient tracking information in a central location as required for resource management services and the department's information system.
- Use not more than two percent of state-appropriated community mental health funds, which shall not include federal funds, to administer community mental health programs under RCW 71.24.155.
- Collaborate to ensure that policies do not result in an adverse shift of mentally ill persons into state and local correctional facilities.
- Work with the department to expedite the enrollment or re-enrollment of eligible persons leaving state or local correctional facilities and institutions for mental diseases.
- Coordinate services for individuals who have received services through the community mental health system and who become patients at a state mental hospital.

There are, of course, conflicts inherent in these roles, since the RSNs are both supposed to contract for the services consumers need and to manage them prudently and cost-effectively. The policy language contained in the statutes around the RSNs and the MHD contains ample vision for local service integration and coordination, recovery services, early intervention, and innovation. However, the original funds "carved out" of the general Medicaid budget for mental health services did not include those kinds of services and those funding levels per capita have not expanded much.

So these new services, if they are provided, needed to be funded out of savings or through innovative partnerships with other entities in local government. And note that the "savings" resulting from not using a psychiatric hospital bed (the chief generator of managed care savings generally being using less hospitalization) have not been available to the RSNs until recently, given the financial incentives discussed earlier in this section.

Total Population Living within Each RSN Region and Percentage Served



RSN	2004 Population	Service Rate
King*	1,788,300	1.9%
North Sound	1,020,800	1.8%
Pierce	744,000	2.1%
Greater Columbia	630,400	3.0%
Spokane	432,000	2.3%
Clark*	383,300	1.8%
Peninsula	332,400	2.2%
Thurston/Mason	269,300	1.9%
North Central	134,600	2.3%
Chelan/Douglas	102,600	2.5%
Timberlands	95,500	4.3%
Southwest	95,300	4.6%
Northeast	70,100	2.3%
Grays Harbor	69,200	3.4%
STATE TOTAL	**6,167,800**	**2.1%**

MAP SOURCES: 2003 Sub-County Population Estimates by Washington State Department of Health, Vista Partnership, Krupski Consulting: Washington State Population Estimates for Public Health. October 2004. CHART by DSHS Research and Data Analysis Division, May 2006.

Regional Variation in Service Delivery and Service Dollars Spent

RSNs vary widely in both geographic context and population size – from just over 1,600 rural persons served each year in the Northeast RSN to over 33,000 in urban King County. Since 1990, RSNs have had broad statutory authority to plan and allocate services within their regions. Over time, the mental health care service pattern – both services received and costs – has come to differ across those regions.

The tables below and on the facing page show FY 2004 treatment modalities and expenditures for clients living within RSN boundary areas (RSN of service has been imputed from the client's county of residence). All state hospital and most community psychiatric inpatient services are not included in the table. RSNS are providing:

- Individual treatment to 67 to 90 percent of their consumers, for an annual average cost per person between $578 and $1,423 (statewide, 76 percent and $894).

Percent of Consumers Using Different Types of Mental Health Services
By most frequent type of service, FY 2004

Continued on facing page

Modality	Chelan-Douglas	Clark	Cowlitz	Grays Harbor	Greater Columbia	King
Individual Treatment	83%	70%	87%	74%	74%	80%
Intake Evaluation	48%	48%	39%	53%	47%	39%
Crisis Services	26%	29%	31%	27%	27%	28%
Medication Management	15%	22%	19%	18%	40%	32%
Family Treatment	13%	24%	7%	20%	9%	23%
Group Treatment Service	7%	7%	3%	2%	11%	11%
Medication Monitoring	19%	39%	8%	21%	11%	10%
Non-State Plan Services	3%	2%	2%	3%	1%	15%
Rehabilitation Case Management	0%	0%	0%	0%	1%	3%
Day Support	0%	2%	0%	0%	2%	5%
Freestanding Evaluation, Treatment	0%	0%	0%	0%	0%	2%
High Intensity Treatment	4%	4%	3%	0%	1%	0%
Mental Health Residential Treatment	0%	0%	0%	0%	0%	2%
Peer Support	4%	0%	0%	0%	0%	4%
Stabilization Services	2%	2%	0%	4%	0%	1%
Therapeutic Psychoeducation	11%	0%	0%	0%	3%	0%
Respite Services (B3)	0%	0%	0%	0%	0%	2%
Supported Employment (B3)	0%	2%	3%	2%	0%	1%
Psychological Assessment	0%	1%	0%	0%	0%	0%
Clubhouse (B3)	0%	0%	1%	0%	0%	0%
TOTAL	**2,476**	**6,837**	**4,446**	**2,349**	**18,666**	**34,899**

Dollars Spent Annually Per Consumer for Mental Health Services
By region, for each type of service, FY 2004

Continued on facing page

Modality	Chelan-Douglas	Clark	Cowlitz	Grays Harbor	Greater Columbia	King
Individual Treatment	$825	$1,232	$817	$670	$704	$1,007
Intake Evaluation	$130	$124	$116	$111	$118	$132
Crisis Services	$991	$914	$250	$247	$234	$2,073
Medication Management	$102	$67	$183	$92	$162	$154
Family Treatment	$325	$515	$246	$305	$310	$281
Group Treatment Service	$775	$570	$845	$337	$1,702	$1,922
Medication Monitoring	$211	$183	$489	$136	$46	$121
Non-State Plan Services	$68	$30,498	$137	$6,291	$64	$86
Rehabilitation Case Management	$206	$65	$320	$173	$223	$122
Day Support	$69	$3,974	$50	$0	$11,905	$7,038
Freestanding Evaluation & Treatment	$6,371	$0	$20,109	$3,294	$6,769	$7,190
High Intensity Treatment	$372	$640	$417	$58	$270	$11,893
Mental Health Residential Treatment	$1,230	$10,482	$123	$7,177	$205	$18,760
Peer Support	$2,112	$564	$24,374	$1,179	$1,031	$3,142
Stabilization Services	$11,039	$1,359	$301	$9,185	$1,365	$8,304
Therapeutic Psychoeducation	$103	$121	$223	$0	$92	$98
Respite Services (B3)	$0	$0	$225	$263	$684	$757
Supported Employment (B3)	$0	$502	$337	$351	$1,061	$842
Psychological Assessment	$77	$155	$944	$0	$98	$308
Clubhouse (B3)	$0	$0	$5,827	$0	$6,064	$634
TOTAL	**$3,132**	**$2,998**	**$2,013**	**$2,341**	**$2,079**	**$4,305**

- Crisis services to 25 and 50 percent of their consumers, for an annual average cost per person between $225 and $2,073 (statewide, 32 percent and $935).
- Intakes/evaluations to 31 to 53 percent of their consumers, for an annual average cost per person between $101 and $160 (statewide, 41 percent and $124).
- Medication management to 11 to 40 percent of their consumers, for an annual average cost per person between $67 and $207 (statewide, 30 percent and $161).
- Family treatment to 3 to 24 percent of their consumers, for an annual average cost per person between $215 and $597 (statewide, 9 percent and $363).
- Group treatment to 2 to 15 percent of their consumers, for an annual average cost per person between $570 and $1922 (statewide, 11 percent and $1,519).
- Medication monitoring to <1 to 39 percent of their consumers, for an annual average cost per person between $51 and $489 (statewide, 9 percent and $150).

Table continued from facing page

North Central	North Eastern	North Sound	Peninsula	Pierce	Spokane	Thurston-Mason	Timberlands
89%	85%	70%	79%	67%	80%	74%	71%
41%	44%	41%	37%	31%	43%	48%	40%
27%	13%	37%	36%	50%	26%	31%	25%
11%	21%	29%	34%	29%	37%	33%	17%
3%	8%	7%	10%	16%	15%	9%	9%
9%	12%	14%	15%	10%	15%	14%	5%
13%	5%	0%	0%	1%	0%	8%	27%
4%	0%	0%	1%	0%	0%	1%	13%
1%	0%	5%	1%	0%	0%	0%	0%
0%	0%	1%	6%	0%	2%	1%	1%
0%	0%	3%	5%	0%	0%	0%	0%
0%	0%	0%	1%	0%	0%	0%	1%
0%	0%	1%	3%	1%	3%	0%	0%
0%	2%	0%	0%	0%	0%	0%	2%
0%	0%	4%	3%	0%	2%	4%	2%
4%	1%	0%	0%	0%	2%	1%	0%
0%	0%	0%	0%	0%	0%	0%	0%
1%	0%	0%	2%	0%	0%	1%	4%
0%	0%	0%	0%	0%	2%	0%	0%
0%	0%	0%	0%	0%	3%	0%	1%
3,011	**1,684**	**18,043**	**7,515**	**15,854**	**10,433**	**5,721**	**3,974**

Table continued from facing page

North Central	North Eastern	North Sound	Peninsula	Pierce	Spokane	Thurston-Mason	Timberlands
$578	$943	$678	$766	$995	$993	$795	$1,423
$117	$118	$101	$115	$111	$160	$140	$140
$216	$693	$447	$587	$1,034	$884	$225	$322
$73	$88	$165	$207	$180	$184	$182	$85
$215	$216	$326	$395	$597	$373	$316	$446
$1,610	$1,031	$1,130	$1,723	$1,649	$1,582	$889	$636
$104	$51	$81	$135	$97	$127	$67	$301
$52	$0	$95	$57	$2,886	$76	$474	$687
$86	$584	$345	$63	$195	$302	$225	$274
$0	$6,023	$4,141	$10,700	$5,659	$13,319	$2,562	$766
$0	$32,254	$11,230	$8,531	$6,345	$3,982	$5,873	$5,063
$622	$0	$963	$1,880	$17,283	$576	$591	$396
$0	$5,845	$22,605	$4,292	$13,095	$17,442	$11,855	$1,477
$81	$2,157	$554	$2,692	$618	$800	$594	$1,205
$5,728	$3,701	$5,101	$20,034	$6,311	$4,090	$6,905	$14,985
$38	$982	$76	$35	$198	$2,245	$297	$129
$259	$0	$3,406	$0	$2,078	$598	$1,058	$102
$1,092	$0	$98	$349	$182	$846	$308	$774
$0	$92	$0	$0	$369	$444	$304	$0
$0	$1,243	$1,898	$0	$0	$9,485	$17	$191
$2,306	**$2,749**	**$2,921**	**$3,811**	**$6,297**	**$5,917**	**$2,516**	**$2,294**

Peer Support and Peer Services

We are hiring peer-support persons, who are required to be out in the community, and looking for improvement and recovery." (RSN Director)

MHD agrees that the state needs more peer support programs. They are vital for all consumers; they are particularly valuable among underserved groups and people living in more remote areas.

- There are now more than 125 certified peer counselors across the state. The Washington Institute for Mental Illness Research and Training holds the contract for Peer Counselor training, coordinated by the MHD.
- The *Community Connector* project continues. There are currently about 30 Connectors providing support in the state. Connectors continue to be parents or caregivers of children with complex mental health needs.
- Clubhouses are growing and become more standardized. Innovative clubhouses (such as a virtual clubhouse) are also being formed.

Some RSNs, however, think there is no funding for these sorts of services.

"There is no funding for peer support." Urban RSN Director

"Need to re-consider the range of available services. Need to redefine funding modalities. The rehabilitative services don't mix with Medicaid criteria and the 'billable services'." (Urban RSN Director)

"Need to provide more social and recreational or pre-employment support." (Urban RSN Director)

"Recovery" Services

"In a transformed system, RSN and providers would have high expectations for some consumers to leave system … staff and providers would be 'hopeful' and expect recovery for every consumer. We would expect more consumer growth and change." (Urban RSN Director)

"In a transformed system, we would focus on managing illness, increasing housing, employment, social life of SPMI population." (Urban RSN Director)

Some RSNs are doing this now, leveraging existing funding and working in community teams. Others are waiting for transformation – or at least for training money.

Jobs, School and Housing

"We need to pay more attention to what people really need… stable housing and jobs … and schooling and training."

The Mental Health Division has few strong policies around jobs, housing or schooling and work training. Those aspects of recovery work have been left to the RSNs to incorporate and to other agencies (such as the DSHS Division of Vocational Rehabilitation).

Jobs and Job Training

Given that many MHD consumers are on SSI or GA "disability" funding, which is predicated partly on functional disability in relation to employment, it is probably not surprising that employment among MHD consumers between 18 and 65 is low—only about 16 percent were receiving income recorded in the state Unemployment Insurance records or from supported employment. And the employment target for RSNS – that they maintain at least 10 percent of their working age adults in employment – is hardly a "stretch" goal.

However, RSNs are very interested in getting transformation help with employment. Particularly in the small RSNs, help, flexibility and creative ideas are needed.

"RSN is providing support for Clubhouse. Clubhouse has employment program. DVR is not available in our small county; has no presence here." (Rural RSN Director)

"A transformed system would include a peer counselor system, and an expanded club house + peer employment at clubhouse, as well as creating employment opportunities at club house, with providers, in the community, + job-training opportunities. Would also have Need certified peer counselors (WIMIRT can train 25 persons /semester) and training opportunities at community college." (Rural RSN Director)

"Consumer employment: RSN bought coffee-making machine, trained consumer as Barista, sells coffee in MH center. Also have a catering service and bakery Service. Other sustaining services in the works." (Urban RSN Director)

"Consumer employment is important – we have 8 people employed in a clubhouse. Have DVR on board. We want to use state-only money that venture." (Rural RSN Director)

MHD staff and some RSNs say that more supported employment is needed and those goals have also been written into the Block Grant plan. Other RSNs don't want supported employment; they want stigma reduction and help for consumers to get "real" jobs.

"Current employment relationship with DVR should change. It is crippling the ability to develop 'real' employment. Employment must be important enough to have state-directed programs with money and training resources behind a coordinated effort." (Urban RSN Director)

Housing Support

In its 2006 Block Grant Plan, the MHD's policy focus on housing was mostly around engaging homeless persons in treatment (pages 48 through 50).

However, the major RSN focus has been on developing housing resources, both in the high-cost Puget Sound area and in rural areas. RSNs can (and some do) work in community coalitions to develop small group housing settings and some allied services. But they would like more help from MHD in this area.

"Examine/create new avenues to re-configure housing for mentally-ill persons. We are losing affordable housing rapidly. Small motels are going out-of-business. Cost of housing going up, M.I. + inmates recently out of prison or local jails cannot find place to stay. We are trying to work with HUD—not overly successful. Need MHD to take lead state-wide on housing issues." (Rural RSN Director)

Can't talk about recovery if people are homeless. Estimated number of mentally ill without housing is 3000 to 4000 persons. This issue is connected with SSI Disability payments. Can't have 'hope' if your payment is $579.00/month and housing is $600.00/month minimum. Need to have an SSI payment differential in cities to meet cost-of-living issues." (Urban RSN Director)

"Need more apartments. We rent 6 units at present time. Has med management available plus staff present 16 hours/day." (Rural RSN Director)

"No funding for housing development. Housing shortages in this area are critical. It is very expensive to live here." (Urban RSN Director)

RSNs also want to develop transitional housing with some services attached, which they think would help divert people from hospitals. Some have managed to do that by leveraging HUD funds; others have had difficulty. They would also like help from MHD in this area.

"Our RSN owns a 40 transitional bed unit which provides STABLE HOUSING a major key to success of consumers. We have tenant-based rental assistance from HUD which covers 2/3 rent payments for most clients. In all, our RSN has $2 million for transitional services and housing response." (Urban RSN Director)

*"Major gap is the state hospital. The clients can't be relocated into the community, because they have reached maximum psychiatric benefit but deemed unfit for the community. Would use new monies to buy housing in the community for enhanced care unites (24/7 care—built on models in Oregon) for fire-setters, sexual predators, etc. Contract for closed units with appropriate controls—cheaper than hospital and would clear up psychiatric beds." (*RSN Director)

"We need control over residential beds—need HSC at table. Need licensing change, to get people out of institutional beds. Landlords have major issue, if persons in community setting have background of arson, criminal activities, and/or sexual predators, then insurance companies cancel policy." (Urban RSN Director)

"RSN needs funding for housing. Need to be able to create residential services." (RSN Director)

Consumer and Family Voice

"There's a strong effort made to involve consumers at all levels. This goes all the way from individual treatment plans to making agency policy." (Mental Health Division)

"MHD needs to create a model for a consumer-led system, where staff are supported and respected." (Rural RSN Director)

"A transformed system would monitor, validate and measure consumer and family participation in their treatment. "(RSN Director)

"Consumer voice is NOT guiding treatment; Consumer voice is Not working. In reality, there is NO consumer voice at our RSN." (Rural RSN Director)

Consumers Influencing RSN/MHD Policies and Practices. Part of this movement is to ensure that a consumer voice is heard around policy and practice.
"Quality Review Team is 80 percent consumer. Very excited about changes." (Rural RSN Director)

"Consumer values are important input to RSN Advisory Board." (RSN Director)

"A transformed MH System would be a more consumer-driven system." (Rural RSN Director)

Within the MHD, Sandy Gregoire and Bonnie Staples are currently employed consumers or family members. Sandy Gregoire is the Parent Advocate providing support and information to parents and Bonnie Staples is the Peer Support coordinator providing support to applicants, reviewing applications, scheduling training and testing. Currently, the Director position of MHD Office of Consumer Advocacy (OCA) is vacant.

There is a statewide parent/youth group. That group is called Statewide Action for Family Empowerment of Washington (SAFE-WA). SAFE-WA is in its 5th year of operation with youth being members for two years. SAFE-WA membership consists of representatives from local parent & youth groups. Their role is to provide a common voice on issues of parents and youth to the MHD and others around children's mental health issues. SAFE-WA participates with the MHD, the Transformation Grant, the Children's Mental Health Initiative and state and local advisory groups.

Some RSNs have organized local parent and/or youth groups. Principally, those with well-organized and running groups are the urban, single county RSNs—Pierce, Clark, King and Spokane.

The MHD is providing registration for adult consumers to attend the Alternatives conference, a recovery conference for adult consumers sponsored by SAMHSA.

Consumer-Led Treatment. Another important consumer focus is designing a system that facilitates consumer-led treatment decisions.

"Need to get clients to focus on their own treatment plan." (Urban RSN Director)

"A transformed system would be consumer focused and directed. Consumers would be less dependent in MH and rely on themselves, peers and community resources." (Urban RSN Director)

Training Targeted to Consumers and Families. MHD sponsors a number of these trainings, including the following:

- Wellness Recovery Action Plan (WRAP) training, which is scheduled to begin five sessions of training in the summer of 2006 for adults, and there is conversation occurring about a specific class for youth. "WRAP stands for Wellness Recovery Action Plan™. WRAP is a self-management and recovery system developed by a group of people who had mental health difficulties and who were struggling to incorporate wellness tools and strategies into their lives. WRAP is designed to: decrease and prevent intrusive or troubling feelings and behaviors; increase personal empowerment, improve quality of life and to assist people in achieving their own life goals and dreams."
- Two parent trainings per year. This past year there has been has a growing emphasis on Father's groups, with three this year.
- Eastern State Hospital provides Family Education Workshops for the community - quarterly onsite at hospital for providers and family members with breakout sessions for the major psychiatric diagnoses, e.g. depression, bipolar disorder, and schizophrenia. All are taught by hospital staff.
- MHD contributes to the Behavioral Health Care Conference and to provide scholarships for consumers and families.
- MHD, other DSHS agencies and consumer and family organizations have teamed together to provide trainings to target specific needs in the mental health community. A training developed through the Children's Mental Health Initiative, and provided by Statewide Action for Family Empowerment of Washington (SAFE-WA) for parents/ youth on Evidence-Based Practices (EBPs). This is accomplished using a manual developed by SAFE-WA members and approved by the Department. They have done at least 14 such trainings across the state. SAFE-WA is currently in the process of writing an informational brochure (similar to the parent's guide to mental health) on what to expect from Evidence based Practices. Once reviewed by the Department, they will pilot the brochure and finalize it. This contract is funded jointly with MHD, CA, and JRA and sponsored by the three Assistant Secretaries and managed by the MHD. SAFE-WA continues to provide Wrap-Around training to parents and youth and training or mentoring on how to work within the system.

Service Integration and Coordination

*"There is a silo effect even in our community: there is no flexibility in funding to meet needs of joint clients." (*RSN Director)

"Our RSN has effective collaboration across systems. We have blended funds and meet with multiple agencies monthly, at least, including Children's Administration, school district, 2 family members, 2 provider agencies, Juvenile court rep, DD person, Substance Abuse agency reps." (RSN Director)

It is very clear to mental health professionals that many consumers have multiple problems which make "team" treatment useful. Nonetheless, organizational "silos" can be very difficult to overcome. Integrated work needs to be targeted carefully.

A good deal of integration is going on at the state level, or in pilots in individual counties. The Mental Health Division is working as an active partner in a number of key service integration efforts.

- *The Children's Mental Health Initiative.* Partners are the DSHS Children's Administration (child protection and welfare) and the DSHS Juvenile Rehabilitation Administration. The three programs are braiding funding and resources to develop a common set of Evidence-Based Programs in the community, with which all three programs can contract.
- *The Washington Medicaid Integration Partnership Pilot.* Partners are the DSHS Aging and Disability Services Administration, DSHS Medical Assistance, and DSHS Division of Alcohol and Substance Abuse. The four programs are jointly blending funding in a pilot program in Snohomish County, working with one health plan provider (Molina) to manage health, mental health, chemical dependency and long-term care, using an actuarially established capitated rate.
- *A-Teams.* "A-Teams" consist of local agencies involved in caring for multi-problem persons with disabling health conditions. Mental health partners at the local level generally include local or regional managers from DSHS long-term care, developmental disabilities, alcohol and substance abuse, sheriffs, police chiefs and jail/DOC. Agencies take turns presenting and teaming particularly difficult cases, braiding funding as needed, and collaborating closely in case management.
- *Expedited Medical Benefit Review.* Partners are Department of Corrections, local jails, Washington Association of Sheriffs and Police Chiefs, DSHS Economic Services, and DSHS Medical Assistance. Partners are working to improve the institution/community transition for persons with mental illness, by expediting the establishment of medical benefits so they are available upon release.
- *Expanded Community Services (Geriatric) and Developmental Disability Collaborative Work Plan.* Partners are DSHS Aging and Disability Services Administration (both long-term care and developmental disabilities). Programs consist of developing secure community alternative placements for persons residing in mental health state hospitals who do not need that level of service.
- *Families and Communities Together Pilot.* Partners include most of the social service and community providers in Whatcom County. Project is a locally designed initiative aimed at building a comprehensive family support system, with common needs assessment protocols and many integrated service sites.
- *King County Systems Integration Initiative.* Partners include local child welfare, economic assistance, schools, health departments, and juvenile justice services for youth. Project is designed to connect them.

RSNs would like more help in local service integration during transformation.

"A transformed system would have better client relationships with CSOs. We need better tracking of client's progress through CSO eligibility maze, better handle on inpatient client eligibility—fast-tracking." (RSN Director)

"We need physically integrated health care. Look for pilots in the state to copy. MH, Physical health, and DASA need to be co-located—especially in rural areas. (Example: Okanogan County couldn't find a psychiatrist, so used primary care physicians and ARNPs. They needed prescribers, so they co-located psychical health and mental health facility. They now have a new private non-profit so they have Substance Abuse, MH and primary health care in one building. The local MH clinic wouldn't help, so they re-organized—but still try to cooperate with the clinic." (Rural RSN Director)

"Need more funding or flexibility to collaborate w/DD contracts meeting client needs." (Rural RSN Director)

Co-occurring chemical dependency and mental illness. Despite much attention in recent years, this service coordination issue remains problematic. Cross-certified programs are needed, one MHD staffer said. The confidentiality barriers in both directions make braided programs difficult. Earlier intervention and screening in both directions are also needed.

"Frequency of co-occurring disorders is rising. Need to reduce boundaries between RSN and other agencies). Need training to bring up psychiatric competencies for MH/DD issues. Need to co-locate MH in other agency venues." (Rural RSN Director)

"Need to interact more with DASA over those identified with co-occurring disorders—used to have a more unified system a long time ago." (Urban RSN Director)

"Need better coordination with DASA around clients with co-occurring disorders." (RSN Director)

*"Co-occurring collaboration. Need single or blended funding. The mentality is different, for a trained co-occurring SA-MH worker."(*Rural RSN Director)

"The split between MHD and DASA is a problem. This split, in monies and policy complicates treating co-occurring clients. We need common training with substance abuse… Need monies from Federal Block grant dedicated to co-occurring population. Need staff with co-occurring training plus licensing and certification." (Rural RSN Director)

Geographic Barriers to Mental Health Coordination. Several of the single-county RSNs are working on service integration and coordination at the local level. However, the multi-county RSNS have some difficulty coordinating at the local level, since they do not have common boundaries with any other single government entity. Hence within the multi-county RSNS, the coordination needs to be with smaller local entities, one at a time—counties or cities. Conversely, because there are fourteen RSNS, it is very difficult for state agencies to coordinate with them. So multi-county RSNs have a difficult time finding coordination partners.

Coordination Training. WIMRT offers a Case Management Academy for Adults with Co-occurring Mental and Substance Abuse Disorders and Case Management Academy for Youth with Co-occurring Mental and Substance Abuse Disorders.

Coordination Technology. This is an area where work is clearly needed; integration projects founder on the lack of a common health record, where each partner can record actions, diagnoses, needs and treatments provided. See "Integrated Health Records" below for the current situation.

Access to Service in Rural Areas

Small and rural RSNs have problems with state agencies at county or regional level, and with other community and county agencies in getting them recognizing and responding to the mental health needs of consumers. They also have difficulty finding any partners who understand the consumers or can help with recovery services.

"This is a small community. It is difficult to predict responses between agencies/ systems at local level." (RSN Director)

*"Police and Sheriff's departments are small and NOT trained around mental health issues … Jails aren't educated about ITAs want people disturbing their jails—gone!" (*RSN Director)

*"Commissioners and conservatism and stigma wears down and defeats innovation." (*RSN Director)

"There is a mind set in county government that discourages collaboration and service to people." (RSN Director)

*"Our regions don't match. Other agencies seem not to have understanding of RSN boundaries, constraints and abilities." (*RSN Director)

There are also steep fiscal limitations and liabilities in small counties. If there are little or no extra state funds, then monies for outreach programs are cut, leaving programs to die. These are typically very small amounts of monies and seed monies, but the lack of these programs strangles outreach to typically underserved groups: elderly, children and Indian tribes.

The RSNs are particularly aware of this problem now that they are unable to use Medicaid "savings" to fund some of the outreach and "non-billable" programs they were able to use it for previously. This was particularly problematic for small rural RSNs.

"We need funding to restore the programs that used to work, but now not functioning after 'Medicaid–savings' of funding disallowed. These are relatively small amounts annually, but with high over-head for paying for community beds, and no state monies, we had to cut back our Gate-keeper program (EBP outreach program for elderly). This program started in 1998, and cost $20,000 to $30,000/year -- allowed elderly person to remain in community with over-sight and support. Results: People not able to live in their homes. Also, the Geriatric Outreach program to keep people out of nursing homes stopped. RSN is now seeing more severe impairment with elderly." (RSN Director)

"Mental Health Case aide service (personal services providers) respite services, mentoring, aides for older adults, and children, Tribal outreach (both Tribes) Club house, and Wraparound services have all been cut. The tribal outreach cost about $20,000 and funded culturally relevant services. The tribe refused to collaborate with RSN when this program as pulled. Children's program with case manager especially for homeless youth/ hard-to-reach kids had to be pulled. Prevention and early intervention programs had to be cut back. Result was huge impact on Consumer services. Loss of money caused RSN to make choices about services and outreach which were less expensive." (RSN Director)

"It is like having company over and having a cupboard full of wax-fruit. Nice looking but useless." (RSN Director)

Being rural also affects staff size and breadth and what can be done.

"There are no consumers working in our RSN—the staff is too small to recruit, train and provide necessary supervision." (RSN Director)

Early Intervention, Screening and Referral

For Children and Families

RSNs and the MHD agree that a transformed system would change the rules so that families and children get into services together at the right time—before the situation has become hopeless.

"We need a completely different system for treating families and children. It should include primary care, and a central system for referring kids and families to treatment managed through a medically integrated system. We need referrals from schools and medical system. It should be built into a health care system, with a 'vestment' strategy that would include juvenile justice and the schools. The trigger for MH need would pool entitlements and have a community—based treatment plans. I'd recommend 30 hours of intensive work for children, with clear provider plan for who does what—plan needs structure. Plan should be approved at local level, go up to RSN/State than back to community to trained teams. It would be comprehensive (similar to ACT) with a director of Services. We need schools at the table." (MHD Director)

"Integrated children's mental heath must be organized and funded. The schools must be involved, and we must insure collaboration, exchange of information, and training, and stigma reduction, particularly for children's mental health needs." (Mental Health Division)

RSNs are acutely aware of this issue as a possible transformation focus.

"Deal with issues of children not meeting criteria for Medicaid standards of treatment; Provide mechanism to fund prevention services for small children & families. Prevention /parenting support for low-income families." (Rural RSN Director)

Access to care standards are not flexible enough to allow children in; have to 'game' the system to allow psychiatric help for children. (Rural RSN Director)

"A transformed system would include prevention services. RSN cannot provide services, nor can they be accessed by families and children (and others) in need.

"There would be a focus on prevention and a youth and family link -- there are better success rates when families work together in therapy." (Rural RSN Director)

"Prevention is needed; we would need a new Medicaid waiver to be able to provide these services. Would include family psycho-education, early childhood prevention, work with schools." (Rural RSN Director)

"Children and families become issues with early intervention/prevention. Regulations don't meet medical necessity test, so children and families have to become acute before interventions can be made." (Rural RSN Director)

For Everyone

Early integration isn't just about children and families. It is also about reaching people before they are in crisis with services that stabilize them and increase their chances of recovery.

"Reaching persons before they become critically ill *should be a goal of a transformed system."* (RSN Director)

"Individuals need early identification and screening." (Rural RSN Director)

"Transformed system would be more proactive – go out and engage people; get them into recovery services earlier. Issue: Can't bill Medicaid, until identified patient is assessed. Could we use State money to fund links, and continue to treat with state monies?" (Rural RSN Director)

Improving Service Quality

RSNs are really interested in evidence-based practices, but they are also concerned about them – particularly rural RSNs.

"RSN has significant concerns about evidence-based practices. 'Evidence' is not there for rural practice nor normalized for ethnic groups." (Rural RSN Director)

"We have insufficient resources to maintain on-going practice on EBPs, and Medicaid reimbursement doesn't allow training. Providers need training to begin and on an ongoing basis to maintain with fidelity" (Rural RSN Director)

"Establish Evidence-Based Practices with a rural fidelity, tuned to rural communities" (Rural RSN Director)

"Focus on evidence-based practices. Look at Feds' 'Holy Six,' list of EBP. Examine EBPs for fidelity in rural areas; may need flexibility to make programs work in rural community. For example, sometimes programs require 24/7 coverage which means high overhead in a small place." (Rural RSN Director)

"Best practices/fidelity issues not addressed at present." (Rural RSN Director)

Some RSNs point out that better outcome and performance measures could lead to care improvement.

"Need to change what we are measuring as outcomes. Need employment (better measures) and some measure of recovery implementation." (Urban RSN Director)

"There is no consistent measurement of outcomes across the state." (Urban RSN Director)

"A transformed system would have clear recovery-oriented outcomes." (Rural RSN Director)

The Mental Health Division has been working consistently on a statewide data plan to create both outcome data and needed performance measures, under the auspices of federal grants from MHSIP (Mental Health Statistical Improvement Project), under the Centers for Medicare and Medicaid Services (CMS) at the Substance Abuse and Mental Health Services Administration (SAMHSA). The long-term result of this series of MHSIP Information Technology grants was to build the template and outcome data for the current Statewide Performance Indicators. Mental Health Division and RSN Information Technology staff had a long-term collaborative working committee to insure RSN buy-in on a new statewide data system. See Indicators: http://mhdintranet.mhd.dshs.wa.gov/Intranet_Documents/Research/FINAL2_PI_REPORT_08_30_05.pdf.

The first Prevalence Estimation of Mental Illness and Need for Services (PEMINS) study (to estimate prevalence data on mental illness based on Washington State data) was accomplished by the DSHS Research and Data Analysis (RDA) and Charles Holzer, a Psychiatric Epidemiologist from the University of Texas. This study was built upon a 1993-94 household survey funded by the Division of Alcohol and Substance Abuse through a SAMSHA Center for Substance Abuse Treatment contract. Over 7,500 households in Washington State, over-sampling for poverty, race, region and gender. A specially designed section of the study asked questions about DSM IIIr mental illness (questions and scales were drawn from the first National Co-Morbidity Survey). Those households giving positive answers to screens for thought disorders were called back by a licensed psychologist and re-interviewed using a structured clinical interview, to determine whether they were actually mentally ill or simply "odd." The prevalence rates from these surveys were cross-referenced with Census PUMS data to get an accurate distribution of prevalence across Washington State. It can be found at: http://psy.utmb.edu/estimation/mhdprev/html/project.htm.

Integrated Health Records

"Consumers would benefit from a card system, a smart card, used to purchase services and allow for flexibility, and does away with artificial boundaries." (Rural RSN Director)

"Our RSN also uses Trilogy software from SAMHSA—a web-based consumer-oriented sites. Individual families have the ability to put personal services on a secure web-site and give access to service providers." (RSN Director)

"Our RSN has integrated IS system for Netsmart. Five or six other RSNs use this system now active in 13 counties—it contains electronic health record. We have this up and running with MH + SA system, and are working with other counties to get DD on line. JLARC study cited this IS system as innovative." (RSN Director)

Neither the need estimates nor the outcome data above are useful for integrated clinical work with clients. Except for employment and criminal justice arrests and convictions, the data are collected by interview, only for samples of consumers, and are used for generating rates of coverage and rates of outcomes. Here it is some of the RSNs, actually working on service coordination at the local level, who are the most innovative in finding ways to create integrated health records. However, fourteen different integrated health record systems are not going to effectively integrate care!

The 2006 Washington State Legislature passed a bill (SHB 2573) which directed the state Health Care Authority to "promote and increase the adoption of health information technology systems, including electronic medical records" and to "coordinate a strategy for the adoption of health information technology systems" (Section 2-B). The DSHS Health and Recovery Services Administration (which includes the Mental Health Division) is participating in a Governor-led Task Force to assist in these strategies. Hopefully these efforts will lead to a system in which all RSNs and all health plans could participate.

Chapter 6 | Non-Mental Health Agency Interviews

JULY 2006

PRELIMINARY | Still Under Review

NON-MENTAL HEALTH AGENCY ADMINISTRATORS AND KEY MANAGERS SPEAK

By DSHS Research and Data Analysis Division

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ABSTRACT

Common Concerns: Representatives of 16 programs spread across eight different Washington State agencies were interviewed to ascertain what mental health-related services are offered to their clients, what mental health-related services their clients are lacking, and what changes (within their agency, and throughout the state mental health system) they recommended. All respondents stated that certain populations (the young, the elderly, the developmentally disabled, and other persons with specialized needs) have difficulty accessing existing MHD/RSN services, or are in need of specialized services that are not currently available. In particular, respondents stressed the importance of increasing access to stable housing and employment – regarded as a key to recovery for individuals with mental health disorders. They also agreed that prevention and early intervention activities are an important – but often neglected – component of mental health services for all of the state's residents, and efforts in the area should increase. Finally, those interviewed were unanimous in their belief that there must be more effective service integration, communication and collaboration between the various programs serving clients with mental illness if the clients are to be well served and the state is to make the best use of its mental health dollars.

Unique Concerns: Some agencies had concerns unique to their particular clients. Criminal justice agencies spoke of the need for more acute mental health beds within state prisons and juvenile institutions. As it stands now, the state mental health hospitals are ill equipped to serve this population. Agencies serving crime victims, persons with developmental disabilities, veterans, the elderly, and the very young also spoke to the lack of specific mental health services for their particular populations.

Individual Agency Responses: This chapter begins with an overview of agency concerns – the Summary of the agency "voices." Detailed responses of each agency interviewed then follow. Agency responses are organized into four sections:

- Agencies within DSHS (except the Juvenile Rehabilitation Administration, which is rolled into the criminal justice section)
- Criminal justice agencies
- Agencies that serve students and veterans
- Agencies dealing with prevention and/or early intervention

RESEARCH METHODS

A total of 63 comprehensive interviews were completed with 123 administrators and key managers representing the 16 different state programs. Each of the 16 programs provides mental health screenings and/or mental health-related services to clients. Administrators and managers interviewed were asked what was going well, and what was NOT going well, inside their agency and for the mental health system statewide. They were asked to identify "gaps" in the current system, and how those gaps can best be closed.

In addition, agency managers were interviewed in some detail about the current state of the mental health services they themselves manage or contract – policies, practices, service definitions, budgets, and trainings.

Common Concerns

The agency "voices" that emerged throughout the interview process, and in subsequent examination of the data collected, were remarkably consistent. Again and again, agency representatives spoke of their clients' difficulties with accessing existing services, and the lack of appropriate services. They acknowledged clients' need and desire for stable housing and employment, and the various forms of stigma that clients face when attempting to reach these goals.

When speaking of needed changes, each of the agencies stressed the importance of effective collaboration and integration between agencies that share the same clients. They also recognized the importance of reaching out to individuals with mental health disorders as early as possible, before their disorders become chronic.

	Washington State Needs Assessment			
	Gaps by Perspectives			
Washington State Gap Areas Organized Under the President's New Freedom Commission on Mental Health Goals	Voices within DSHS (except JRA and MHD)	Criminal Justice (DOC and JRA)	Schools and Veterans (OSPI and DVA)	Prevention a d Early Intervention
GOAL 1: Mental Health is Essential to Overall Health				
• Access to services	✓	✓	✓	✓
• Stigma and public knowledge	✓	✓	✓	
GOAL 2: Mental Health is Consumer and Family Driven				
• Service choice and quality	✓	✓	✓	✓
• Jobs, school, and housing	✓	✓	✓	
• Care in jail/prison and transition to community care		✓		
• Service integration and coordination	✓	✓	✓	✓
GOAL 3: Disparities in Mental Health Services are Eliminated				
• Access to services in rural areas	✓		✓	✓
• Access to culturally and linguistically appropriate services	✓	✓	✓	✓
GOAL 4: Early Mental Health Screening, Assessment and Referral are Common Practices				
• Early intervention and screening	✓		✓	✓
• School and health care collaboration	✓		✓	✓

Access to Services

There was general agreement among agency administrators and managers that certain populations are not well served by Washington State's current mental health system, and that those with more acute mental health problems receive the lion's share of services delivered. A number of agency representatives underscored the points below:

- The young, the elderly, and the homeless are among the groups that receive the poorest service from Washington's mental health system
- Some populations' access to the mental health system is limited by statute. For example, developmentally disabled individuals must be deemed "at risk for hospitalization" to receive services, and inmates lose their medical coupons and DSHS funding each time they are incarcerated for more than a few days.
- Some populations' access to the mental health system is limited by circumstance. For example, individuals living in rural areas face transportation problems and a lack of local mental health professionals, and persons speaking no (or very limited) English have difficulty locating mental health professionals who can communicate with them effectively.
- Washington State's mental health system, as a whole, fails to serve clients with mild-to-moderate mental health problems. The clients' needs are addressed only when their problems reach a "crisis" stage.

"Why try to determine the mental health problems kids have, if there's no access to services? What's the point?" (Office of the Superintendent of Public Instruction)

"GAU clients have no access, they can get prescription coverage only, but no treatment or counseling services. Providing medications without treatment is a disservice to consumers." (Medical Assistance)

"Very few of our clients are served by the Mental Health Division or other agencies; most of our clients are in the "No One" box." (Department of Community, Trade, and Economic Development - Long-Term Care Ombudsman)

"If you're at risk for hospitalization, you can have them (DDD mental health services); if you're not, you can't." (Division of Developmental Disabilities)

"The lack of local resources for children with mental health disorders, and their families, is lamentable." (Division of Developmental Disabilities)

"Our preference would be to use RSN services, but they don't treat little kids – we need kids' counseling, family therapy, and kids' day treatment." (Children's Administration)

"We end up spending a lot of money on medication and counseling to bring people up to the point they're capable of working." (Division of Vocational Rehabilitation)

"We're not obligated to provide treatment while they (adolescents) are on parole. The problem is, no one else is, either." (Juvenile Rehabilitation Administration)

"Too often, kids leaving JRA institutions can't get into RSNs, or onto Medicaid." (Juvenile Rehabilitation Administration)

"Untreated mental health problems in veterans lead to death, suicide, and many medical issues – most likely diabetes, drinking to excess, homelessness, and disintegration of family. At least 1/3 of Washington's Vietnam veterans are dead." (Department of Veterans Affairs)

"People don't realize that 64 percent of our clients are kids. The community mental health centers aren't prepared to do kids." (Department of Community, Trade, and Economic Development – Crime Victims' Advocacy)

"We serve 18,000 kids. There's 26,000 more kids out these who should be served by us. A lot of those kids, and their parents, have mental health issues." (Department of Community, Trade, and Economic Development – Early Childhood Education Assistance Program)

"Sometimes we just don't have the resources to deal with the problems these kids have, but we can't exclude troubled kids. The Mental Health Division doesn't serve them, so we just have to do our best to build resources around the child." (Department of Community, Trade, and Economic Development – Early Childhood Education Assistance Program)

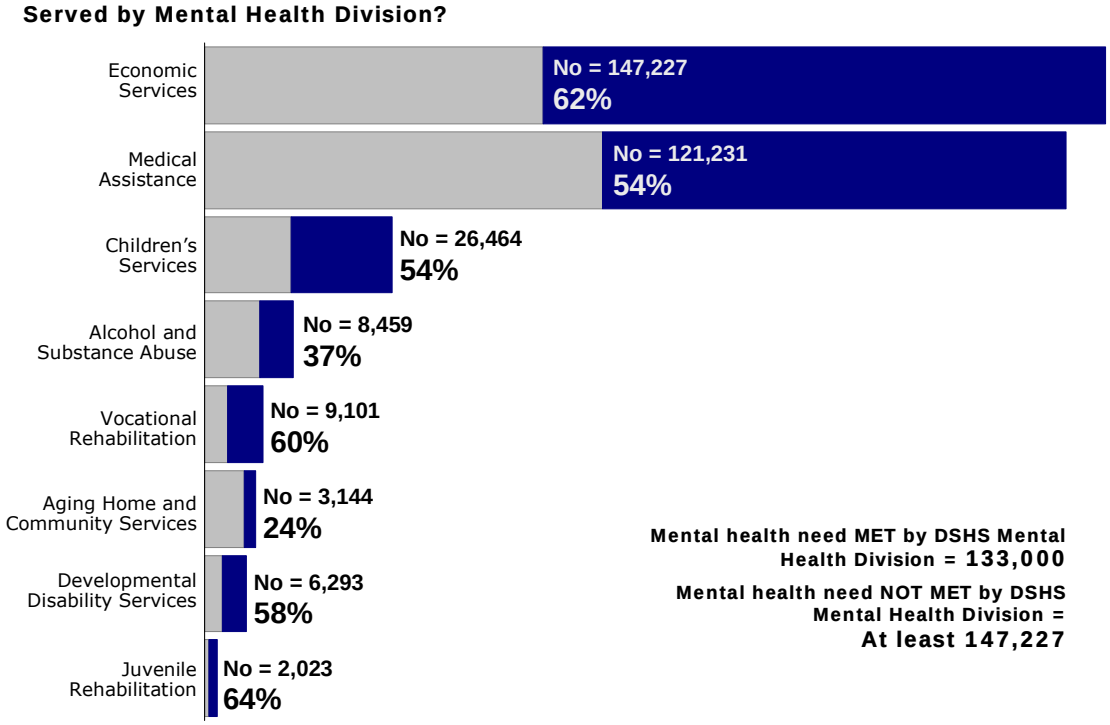
"We see attachment disorders, conduct disorders, and depression in kids all the time." (Department of Community, Trade, and Economic Development – Early Childhood Education Assistance Program)

"All 35 local health jurisdictions see issues with the mental health system, from the 'lens' of WIC, AIDS, co-occurring disorders, the homeless, and so on." (Department of Health)

"If needed mental health services aren't provided, you'll see an exponential escalation of traumatic consequences. These children aren't only at risk for mental health issues, but for medical issues – diabetes, heart disease, even early death." (Family Policy Council)

Mental Health Service within DSHS

In today's system, the Mental Health Division serves less than half the amount of mental health need estimated by other DSHS program administrators.



SOURCE: DSHS Research and Data Analysis Division, Client Service Database

Stigma and Public Knowledge

The stigma faced by individuals with mental illness was noted by several interviewees. Suggestions to promote positive change in this area are identified below:

- Special attention and support must be given to foster children who are mentally ill, as they bear a "double burden" of stigma.
- Employers must be educated about the particular problems faced by individuals who are mentally ill, and shown that these individuals can be a true asset in the workplace.
- A stronger effort must be made to find safe and stable housing for the homeless and persons who live in shelters, as having a home reduces stigma and contributes strongly to mental health
- Alternatives to incarceration must be found for individuals with mental health disorders who are repeatedly "caught" in the criminal justice system. They are often jailed simply for exhibiting "frightening" behaviors they cannot control, and this is a form of stigma.

"In this system, having a mental illness is a double whammy – the child has the stigma of being a foster kid and the stigma of being mentally ill." (Children's Administration)

"It's like this: If you're mentally ill and a criminal, you're going to have a lot of trouble finding a job and a place to live; if you're mentally ill and a sex offender, well, forget it." (Department of Corrections)

"There needs to be a lot more community education about the (mental health) problems veterans face, particularly with employers." (Department of Veterans Affairs)

"Most of our clients who need counseling (after traumatic experiences) don't see themselves as mentally ill, and don't do well when they're sent to (community) mental health centers. They need someplace quiet, and confidential." (Department of Community, Trade, and Economic Development – Crime Victims' Advocacy)

"Mental health issues are probably under-reported, because people fear being fired if they 'fess up'." (Employment Security Department – Governor's Committee on Disability Issues)

"There was a survey that said most employers would rather hire convicted felons than mentally ill folks." (Employment Security Department – Governor's Committee on Disability Issues)

Service Choice and Quality

Agency representatives all provided examples of clear "gaps" in service to the mentally ill. Some of the observations shared were:

- Regional Support Networks (RSNs) offer no trauma-related therapy for children, and little such therapy for adults.
- Children with mental health disorders need more access to child-centered counseling (including attachment therapy) and day treatment.
- Family therapy programs are scarce. Increased attention to family therapy is critical, as there cannot be a healthy child without a healthy family.
- Specific mental health concerns of the elderly, including dementia and depression need much more attention than they are getting now.

"More attention needs to be paid to attachment issues; these often occur when parents have mental health issues. Little treatment is currently available in this area." (Council for the Prevention of Child Abuse and Neglect)

"Consumer-driven services are critical to quality improvement." (Council for the Prevention of Child Abuse and Neglect)

Jobs, School, and Housing

Agency administrators and managers believe that stable housing and employment is vital to recovery for individuals with mental illness, and noted that a growing body of research supports this opinion. Some key comments were:

- Inmates released from adult or juvenile institutions need access to jobs, job training, and housing; drug offenders are not eligible for DSHS funding or housing.
- Proper housing for developmentally disabled clients is scarce. Specifically noted was the limited housing available for Dangerously Mentally Ill Offenders and the shortage of housing and treatment slots for offenders with developmental disabilities in general.
- Many Division of Vocational Rehabilitation clients could benefit from "supported employment" – access to mental health medications and counseling while employed. This type of support often makes the difference between success and failure on the job.

"It's like this: If you're mentally ill and a criminal, you're going to have a lot of trouble finding a job and a place to live; if you're mentally ill and a sex offender, well, forget it." (Department of Corrections)

"Clients decide for themselves when, where, and how much they want to work." (Employment Security Department – Governor's Committee on Disability Issues)

"There was a survey that said most employers would rather hire convicted felons than mentally ill folks." (Employment Security Department – Governor's Committee on Disability Issues)

"We need sustained outreach with employers, so they can come to realize what a talent pool people with mental health disorders really are." (Employment Security Department – Governor's Committee on Disability Issues)

Care in Jails/Prison, and Transition to Community Care

Criminal justice agency representatives spoke of "gaps" in mental health services for offenders who are in custody, and also underscored the need for better transition plans when individuals move from confinement back to the community. They offered the following:

- There are far too few acute care beds for seriously mentally ill prisoners, both in the adult and juvenile institutions.
- The mental health dollars available, both in the state's prison system and in local jails, are spent on those individuals who are most at risk of causing harm to themselves or others. The focus is on safety, not recovery. As a result, many inmates who could benefit from treatment have no access to such treatment.
- Recent budget cuts and policy changes have resulted in fewer adult prisoners receiving mental health medications, while the number of prisoners with mental illness is increasing.
- There is lack of communication between correctional institutions, between prison staff and staff working in probation/parole offices, and between prison staff and community agencies. This results in little (and poor) transition planning for releasing prisoners.
- Once in the community, former prisoners face many roadblocks caused by policies and stigma; they find housing, employment, mental health care, and other social services very hard to come by.

"It's like this: If you're mentally ill and a criminal, you're going to have a lot of trouble finding a job and a place to live; if you're mentally ill and a sex offender, well, forget it." (Department of Corrections)

"In here (a prison mental health unit) we do a pretty good job of stabilizing people in crisis – doing suicide watches, bringing folks down from a psychotic episode – but we aren't set up to help those who are gravely disabled, who are simply unable to take care of their own needs on a daily basis. And we see more and more of those all the time." (Department of Corrections)

"Any good work done here (a prison mental health unit) can be quickly undone if a person returns to the community without access to mental health and other services. This happens all the time, and it isn't long before that person comes back on the chain." (Department of Corrections)

"There's plenty of literature about evidence-based practices around reentry of mentally ill prisoners into the community – DOC pretty much ignores it." (Department of Corrections)

"We're not obligated to provide treatment while they (adolescents) are on parole. The problem is, no one else is, either." (Juvenile Rehabilitation Administration)

"Too often, kids leaving JRA institutions can't get into RSNs, or onto Medicaid." (Juvenile Rehabilitation Administration)

Service Integration and Coordination

Agency administrators and managers were unanimous in their opinion that coordination between programs that serve clients with mental illness is imperative if service to those clients is to improve. They suggested that:

- Mentally ill inmates in state prisons, local jails, and juvenile institutions need community transition plans before they are released from custody. These plans would require ongoing collaboration between criminal justice agencies and local social service agencies.
- Seriously mentally ill offenders need Assertive Community Treatment (ACT) teams, including probation officers, law enforcement officers, mental health counselors, physicians, and employers, to support them in the community.
- Schools and community mental health providers need to work more closely to support students with mental health disorders.
- Schools and veterans' organizations need to work in tandem to support the children of veterans currently deployed, or previously deployed, in war zones.
- All agencies in a given community that serve children and parents should collaborate for the benefit of their common clients.
- Treatment for persons with co-occurring disorders – in both inpatient and outpatient facilities – needs to be developed at a statewide level.
- Mental health treatment and co-occurring disorders treatment must be available to all the state's residents, including those with physical impairments, developmental disabilities, language barriers, remote locations, and other populations with special needs.
- DSHS' Mental Health Division and the Division of Alcohol and Substance Abuse need to work together to develop co-occurring disorders programs statewide.
- The Mental Health Division needs to work with local health initiatives to support prevention activities that promote mental health.

"At least 40 percent of nursing home residents have depression, either organic or situational." (Department of Community, Trade, and Economic Development - Long-Term Care Ombudsman)

"When nursing home or group home clients go into crisis, the Mental Health Division isn't as supportive or timely as it needs to be. We have big problems just getting (the Mental Health Division) there." (Aging and Disability Service Administration)

"People don't realize that 40 percent of the people in adult homes and nursing homes are under 65. They tend to need more therapy and more drugs, partly because they're just in the system longer, and partly because they're depressed about their situation. Wouldn't you be?" (Aging and Disability Service Administration)

"The mental health system is fractured – there's a big breakdown between mental health and CD (chemical dependency). The children's mental health system is totally broken." (Division of Developmental Disabilities)

"We end up spending a lot of money on medication and counseling to bring people up to the point they're capable of working." (Division of Vocational Rehabilitation)

"We need an entry point for mental health services and meds and other services…we have this in a few places, but it's missing in many others." (Division of Vocational Rehabilitation)

"Policies constrain us from serving the mentally ill. RSNs don't want them until they detox; we can't deal with them until they're on psych meds." (Division of Alcohol and Substance Abuse)

"We need truly blended funding with co-occurring services, not just the piece-meal services we have now." (Division of Alcohol and Substance Abuse)

"Why try to determine the mental health problems kids have, if there's no access to services? What's the point?" (Office of the Superintendent of Public Instruction)

"More attention needs to be paid to attachment issues; these often occur when parents have mental health issues. Little treatment is currently available in this area." (Council for the Prevention of Child Abuse and Neglect)

Early Intervention and Screening

Last, but not least, agency representatives stressed the importance of increasing funding and service in the area of prevention and early intervention. They emphasized that:

- All Washington State residents need access to early help for psychological, medical, and environmental problems, all of which can contribute to mental health disorders.
- Every effort must be made to work with individuals as early in the substance abuse cycle as possible, particularly if they have co-occurring mental health disorders.
- Giving an individual with a mental health disorder medication without treatment is a "false economy," as the individual's condition will likely move from acute to chronic without treatment.
- The birth-to-six population needs more therapeutic day care, as early treatment can stem the development of serious mental health problems.
- Persons with developmental disabilities need more prevention-focused "life-skills" activities, such as balancing a checkbook or negotiating a bus route. These activities instill confidence and promote mental health.
- Early attention to maternal depression is important. Such depression negatively affects mothers, children, and family units.

- If veterans do not get "timely" treatment for Post Traumatic Stress Disorder, it can lead to social isolation, poor physical health, substance abuse, homelessness, or suicide.

"We need a stronger focus on prevention – we shouldn't wait so long to offer services, the clients lose a lot when we do this." (Division of Developmental Disabilities)

"We serve 18,000 kids. There's 26,000 more kids out these who should be served by us. A lot of those kids, and their parents, have mental health issues." (Department of Community, Trade, and Economic Development – Early Childhood Education Assistance Program)

"The problem with the Transformation Grant as it's currently organized is that it doesn't deal with prevention and early intervention." (Department of Health)

"If needed mental health services aren't provided, you'll see an exponential escalation of traumatic consequences. These children aren't only at risk for mental health issues, but for medical issues – diabetes, heart disease, even early death." (Family Policy Council)

School and Health Care Collaboration

Agency spokesmen noted some positive efforts currently being made in the area of prevention and early intervention, particularly by schools and health care-related programs. They stressed that such efforts are vital to the mental health of Washington's residents, and should be increased. Some examples given were:

- Early childhood education programs are doing routine mental health screenings, and are providing appropriate referrals for children at risk and their families.
- Attachment therapy (for young children who fail to bond properly with their parent or guardian) is being offered at several of Washington's children's hospitals and clinics.
- In some Washington school districts, partnerships are developing between schools and nearby community mental health centers; in a limited number of schools, mental health professionals regularly spend time on-site in classrooms or in counseling centers.
- Certain school districts in Washington offer suicide prevention programs, violence prevention programs, and substance abuse education and treatment.
- A state-wide campaign to educate Washington residents about post-partum depression will soon be implemented.

"Teachers and (school) counselors, and especially (school) nurses, aren't given enough credit for the good work they do with kids who have mental health problems, and they aren't encouraged to do that work." (Office of the Superintendent of Public Instruction)

"The schools need educating about how to help military family kids." (Department of Veterans' Affairs)

Unique Concerns

In addition to the common concerns, some agencies had unique concerns about the circumstances faced by their clients with mental health disorders. Both the Department of Corrections and the Juvenile Rehabilitation Administration noted the pressing need for more acute mental health beds within their institutions – appropriate treatment is hard to find for offenders, particularly juvenile offenders, at state hospitals. Those working with crime victims spoke to the "poor fit" of the services and the environment at community mental health centers for victims of trauma.

The Division of Developmental Disabilities explained that there is little or no appropriate mental health treatment available for persons with developmental disabilities, particularly for non-verbal clients. Those working with the elderly noted the lack of suitable treatment for persons with dementia, and explained there is a very real need for specialized nursing homes and groups homes for those with specific diagnoses such as Alzheimer's or traumatic brain injury. The state Department of Veterans Affairs stressed that the lack of timely and appropriate treatment for veterans with Post Traumatic Stress Disorder, which can lead to social isolation, poor physical health, substance abuse, homelessness, or suicide. Children's advocates identified the unique difficulties associated with providing services to families containing both mentally ill parent(s) and neglected or abused child(ren).

Individual Agency Responses

The following section details the responses of 17 Washington State programs that serve clients with mental health disorders. The responses are reported under the following headings: policies, practices and organization, training, consumer involvement, and budget. This method of organization is a deliberate attempt to provide needs assessment and resource inventory information in a manner consistent with Mental Health Transformation State Incentive Grant Program guidelines (as outlined in Request for Application 05-009). Information regarding agency data collection and analysis is provided in Chapter 2 of this report, and information relating to facilities and equipment (if applicable) is included in the under the "practices and organization" heading.

The State's Criminal Justice Mental Health Programs

The state of Washington has two different criminal justice mental health programs. The Department of Corrections (DOC) is a state agency that has oversight responsibility for adult felony offenders who are incarcerated in state correctional institutions, in work-release facilities, or on felony-level probation or parole in the community. DOC provides a variety of mental health services inside its institutions, and a very limited number of such services to offenders in community settings, as outlined below.

The Juvenile Rehabilitation Administration (JRA), which functions under the auspices of the Department of Social and Health Services (DSHS), supervises juvenile felony offenders statewide. The Administration's Division of Institutional Programs operates three juvenile institutions, a youth camp, and a basic training camp; its Division of Community Programs operates or contracts with eleven community-based residential facilities, oversees juvenile felons on parole, and partners with county juvenile courts to provide services to youth who need assistance (assessment, treatment, vocational training, etc.) but are not committable to JRA.

Department of Corrections (DOC)

Policies. Per DOC policy (DOC 630.500 and DOC 630.510), mental health services and medications are being provided only to offenders incarcerated in DOC institutions (to include RAP/Lincoln Work Release in Tacoma, a one-of-a-kind work release facility for mentally ill and developmentally disabled offenders), and not to offenders under DOC supervision in the community. There have been recent cutbacks on medications provided in state institutions; those not suffering from severe symptoms, such as psychosis, are no longer "serviced." (In the past, prisoners often received medications for such disorders as ADHD and severe anxiety, but this is no longer the case.)

When offenders are released to the community, they are given a 30-day supply of medications, with the expectation they will access medication in the community. Unfortunately, there is no guarantee they will qualify for Medicaid benefits, and few have the resources to pay for medications on their own.

Practices and Organization. DOC operates fifteen prisons (including the Monroe Complex, which is comprised of four different facilities). Nine of the fifteen prisons offer some mental health services to offenders. DOC has two established "reception centers" in the prison system: male offenders enter the system at Washington Corrections Center in Shelton, while female offenders are sent to Washington Corrections Center for Women in Purdy. Shortly after arrival, each new inmate is screened for mental health issues. Those with presenting problems are further evaluated to determine their optimum placement within the system.

At the present time, DOC has a total of 683 designated mental health beds throughout the institutional system. Four hundred of those beds are at the Monroe Correctional Complex Special Offender Unit (SOU), which serves mentally ill, seriously mentally ill, and dangerously mentally ill offenders. The Monroe Complex also contains the Sex Offender Treatment Program (SOTP), which treats 200 offenders at a time.

Inside the institutions, offenders receive one-on-one counseling, group counseling, and assessments from psychiatrists, psychologists, and mental health nurse practitioners. The level of services varies from facility to facility. DOC administrators estimate that 17 percent of inmates statewide are seriously mentally ill, and that 50 percent of inmates meet some mental health disorder criteria.

Once released from a DOC institution to the community, graduates of the Sex Offender Treatment Program are required to complete the "community phase" of SOTP treatment. DOC Risk Management Specialists provide this treatment, and also oversee the transition of Dangerously Mentally Ill Offenders (DMIOs) and Seriously Mentally Ill Offenders (SMIOs) from prison back to the community.

Some Community Corrections Officers (felony-level probation and parole officers working in DOC offices in communities) are trained to facilitate cognitive behavioral treatment groups such as Anger Management and Moral Reconation Therapy (MRT) intended to address less severe mental health issues. As with institutional services, the level of services varies from office to office. No other mental health-related services are offered to offenders on community supervision, although many offenders are referred by DOC staff to DSHS, community mental health centers, or other local social service agencies.

Training. As noted above, licensed psychiatrists, psychologists, and ARNPs (mental health nurse practitioners) are employed at the majority of DOC institutions. Periodic suicide prevention training is provided for all institution staff.

Although the "guesstimate" is that up to 75 percent of offenders on community supervision have some type of mental health disorder, there is no formal staff training in this arena other than a yearly review on how to "diffuse" angry and agitated offenders. Many Community Corrections Officers do have a great deal of experience working with mentally ill offenders, and a significant number have related training

(psychology, social work, nursing, etc.) as well. Particularly in larger counties, some DOC offices have formal or informal mental health caseloads; the Community Corrections Officers overseeing those caseloads often work out informal collaborations with local mental health centers, substance abuse treatment agencies, hospitals, crisis centers, and housing programs.

Consumer Involvement. The only real "voice" offenders in DOC institutions have is the ability to refuse treatment. Offenders on DOC supervision in the community are sometimes involved in offender-change groups such as Anger Management or MRT, but this is more often by mandate than by personal choice. One DOC Risk Management Specialist, describing his work with offenders transitioning out of prison into the community, offered, "Yes, to work effectively, the offender has to have input into the transition plan, whatever that plan is. This is recognized and handled well by some (Community Corrections Officers), and poorly by others."

Budget. DOC's budget for mental health services was approximately $18.4 million in Fiscal Year 2005, all of which came from the State General Fund. The estimated cost of mental health services provided to the approximately 25 percent of inmates who receive mental health services is $1,200 per client per year. A fiscal manager estimated that an additional 25 percent of inmates have mental health issues, but are not being served within the DOC system.

When a DMIO is released from prison, DOC's Risk Management Specialists (RMSs) oversee his or her transition from prison to the community. There is $10,000 per DMIO per year allotted for housing, treatment, and other services. However, these funds are controlled and distributed by the Mental Health Division rather than by DOC.

Juvenile Rehabilitation Administration (JRA)

Policies. JRA's Bulletin #24 mandates that, if a suicide prevention assessment indicates a youth in the JRA system is suicidal, a designated Mental Health Professional (MHP) will be involved. It also mandates that JRA staff and contracted staff be trained in suicide prevention assessment.

A diagnostic mental health screen is completed within 24 hours of an adolescent being sentenced to the JRA institutional system. (There is a Diagnostic Coordinator in each of the JRA regions; diagnostics is a state function, but it is contracted with the counties in some regions.) A youth must meet one or more of three criteria to be a member of JRA's mental health target population: an Axis I diagnosis (except a single diagnosis of Conduct Disorder or Oppositional Disorder), an assessment as a suicide risk, or a prescription for psychotropic medication.

If an adolescent is classified Level 3 (the highest level), he or she is sent to either Echo Glen or Maple Lane. At these two juvenile facilities, there are mental health cottages with higher-than-usual staff ratios, as well as slightly lower-level mental health cottages used to "transition" youths back to the institution's general population.

Practices and Organization. The JRA institutional system is comprised of four juvenile facilities. (JRA also operates a treatment foster care program and a boot camp, both in the Spokane area.)

The percentage of residents at each of the juvenile institutions that are currently classified as part of the mental health target population is as follows: Echo Glen, 79 percent; Maple Lane, 75 to 76 percent; Green Hill, 40 to 50 percent; and Naselle, 30 percent. In addition, about half of the adolescents on juvenile parole are classified as part of the mental health target population.

In the mental health cottages at Echo Glen and Maple Lane, Integrated Treatment Models (ITMs), involving both cognitive behavioral therapy and dialectical behavioral therapy, are utilized. When youths who are part of JRA's mental health target population complete their sentences and move onto parole, an effort is made to

transition them to community-based mental health treatment, but this is not always accomplished. As with DOC inmates, youths leaving JRA facilities are given only a 30-day medication supply, with no guarantee they will qualify for Medicaid or have other access to prescription medication in the community.

All adolescents are offered Functional Family Parole (FFP), which is not specific to those with mental health issues and is not an evidence-based practice. Selected adolescents and their families, recognized by juvenile parole officers as experiencing dysfunction, are also offered Functional Family Therapy (FFT), which is an evidence-based practice. A JRA administrator offered, "FFT may be used more frequently for individuals, or families, where mental health issues are a concern, but this is not documented."

Training. Each JRA institution has an on-site master-level or Ph.D. psychologist, whose primary role is to consult with staff regarding treatment model triage. Each institution also has a Mental Health Coordinator, most of whom have a Bachelor of Arts degree. (There are also Mental Health Coordinators in each JRA region.) Residential Counselors in JRA cottages (mental health, or otherwise) must have a high school diploma.

All new JRA staff complete a two-week academy, which includes one day of mental health-related training. In addition, residential staff are required to attend an annual eight-hour mental health training (presented by an ARNP from the University of Washington) and also Suicide and Self-Harm Treatment Training (which addresses escape, aggression, and risk reduction, and is mandated by Bulletin # 24).

Consumer Involvement. Upon arrival, adolescents incarcerated in JRA institutions are invited to share personal information that helps to determine their optimum placement within the system. To the extent they provide information, services will be tailored to their needs. They retain the right to refuse treatment.

Parolees and their family members are actively encouraged to participate in the parole process, as it is a family-driven model that relies on family feedback. The goal is to build a community support system for the parolee that will live beyond the parole period. Both Functional Family Parole and Functional Family Therapy incorporate periodic parent and youth surveys.

Budget. JRA's budget for mental health services is approximately $3,500,000 per fiscal year, 23 percent being federal funding (Medicaid, and administration costs), and 77 percent coming from the State General Fund. The cost for mental health services per youth per year is between $3,600 and $4,300.

Common Themes

Both DOC and JRA are serving a high, and steadily increasing, percentage of mentally ill offenders. Although not in the business of mental health per se, both agencies have reacted to the needs of their population by providing a variety of mental health services within their institutions. To date, less attention has been paid to providing such services to individuals on probation or parole, although both DOC and JRA administrators stated that the need for more consistent and comprehensive transition and community services for offenders with mental health disorders is clear.

Agencies Outside of DSHS Serving Clients with Mental Health Disorders

The two agencies outlined below do not function under the "umbrella" of DSHS, but must be considered in any discussion of transformation of the state of Washington's mental health system due to the extent that mental health disorders affect the lives of the students and veterans they serve.

Office of the Superintendent of Public Instruction

Policies. The Office of the Superintendent of Public Instruction (OSPI) oversees all of the primary and secondary schools in the state of Washington. The state is divided into nine Educational Service Districts (ESDs), which together contain 296 independent schools districts and approximately 2,200 schools serving 1.2 million students. The 2200 schools are fairly evenly divided between high schools, middle schools, and elementary schools.

OSPI does not provide direct services of any kind. Rather, it is responsible for funding, accountability, and technical assistance to the state's ESDs and school districts. The agency is involved in mental health services (even the making of referrals to such services) only if it is apparent that a student's mental health issues are impeding his or her academic progress.

Practices and Organization. As noted above, OSPI funds school districts through regional ESNs, and sometimes funds a school district directly. It does no direct service, and does not "micro-manage" how distributed funds are allocated.

OSPI is involved with two programs that relate directly to the mental health of students and their families. The first is the "Readiness to Learn" program, which fosters partnerships among schools, families, and communities in order to create opportunities for youth to achieve at their highest learning potential. There is a strong focus on working with students who struggle with depression and lack of academic motivation. At this time, "Readiness to Learn" has 27 grantees statewide, and serves 350 out of 2,200 public schools. The program has an annual budget of 3.2 million, which comes from the State General Fund.

The second mental-health related program is Prevention and Intervention Services. This program involves contracts between the Division of Alcohol and Substance Abuse (DASA) and ESDs. Practices vary from grantee to grantee, and may include Intervention Specialists in the schools, the "Safe and Drug Free Schools" curriculum, suicide prevention, violence prevention, emergency preparedness, substance abuse treatment, and case management for mental health disorders. At this time, Prevention and Intervention Services has 9 regional grantees, and serves 800 out of 2200 public schools. The program has an annual budget of 5 million, which comes from DASA.

Training. OSPI does not fund any specific mental health trainings. The agency sponsors a number of academic conferences each year, which may "touch on" issues such as suicide prevention. Some of the state's ESDs have been awarded federal grants to be used to address prevention in the areas of violence and homelessness, but the grant monies are not routed through OSPI.

Teacher trainings can and often do address awareness of mental health issues faced by students and their families; the value of school/community liaisons, particularly with police and social service agencies; and difficulties with access to systems of care. (The latter issue is particularly problematic in rural areas, where most school districts have fewer than 2,000 students and expanses are wide.)

Trainings such as those described above are provided at the discretion of individual schools or school districts. An OSPI staff member noted that, even when teachers and administrators receive and endeavor to utilize mental health-related training, students in need of services and their families often resist being identified as having mental health problems, and there is no system in place to help troubled students who have not been formally identified as requiring some form of special education.

Consumer Involvement. According to an OSPI spokesman, the degree to which students with mental health disorders and their families are involved in planning and implementing tailored student and family services varies greatly from school to school, as "Some schools are just plain better at giving families and students a 'voice' in what happens."

Observations. OSPI staff noted that, in regard to student's mental health, much good work (both in terms of interventions and referrals) is done by classroom teachers, school nurses, and a wide variety of other school district employees. Unfortunately, teachers must limit the amount of time and attention given to individual students with clearly recognizable mental health problems in order to be responsible to their other students.

An OSPI administrator, when asked how many students in the public school system experienced mental health problems, responded, "Probably at least 50 percent have ADHD, family problems, parenting problems, but it would be hard to prove it". This individual went on to say, "There's very little access to appropriate mental health providers—this is very frustrating for school districts. Why try to determine the mental health problems kids have, if there's no access to services? What's the point?"

Department of Veterans Affairs

Policies. The Department of Veterans Affairs (DVA) has a cabinet-level position in state government. It has operated a state-funded counseling program for veterans since 1984. Per Title 484 WAC, enacted in 1991, DVA services are available to all honorably discharged war-era vets (Korean War, World War II, Vietnam War, Gulf War, Iraq War) living in the state of Washington. There is also a Memo of Understanding in place so that DVA can serve all military reserves deployed to war zones.

The majority of DVA clients are combat veterans, many of whom were seriously wounded. In contrast to the federal Veterans Administration policy, DVA services are also available to veterans' family members. Exceptions to DVA policy are occasionally made so that a dishonorably discharged veteran can be served, usually in situations where the behavior that led to discharge was related to a mental health disorder.

Practices and Organization. DVA provides clinical services to eligible veterans at 31 sites statewide. All services are contracted, and take place in providers' offices or in community settings (such as clients' homes and public facilities). The range of services includes assistance to obtain Veterans Administration disability assessments, psychological screenings, health screenings, Post Traumatic Stress Disorder (PTSD) checklists, and clinical sessions. In addition, DVA broadcasts public service announcements about PTSD, and provides education about and contact information for PTSD providers to Madigan Hospital staff and National Guard units statewide.

DVA also operates three veteran homes (nursing home or assisted living facilities). The Spokane facility has 300 beds, the Orting facility has 100 beds, and the Port Orchard complex has 100 homes.

A DVA administrator estimated the lifetime prevalence rate of PTSD at 30 to 50 percent of all Vietnam veterans, and the PTSD symptom rate of veterans returning from Iraq at 30 to 35 percent. The top diagnoses of DVA clients are PTSD, depression, and anxiety.

Training. The 31 providers contracted by DVA are all licensed mental health counselors, family counselors, or social workers. (Historically, the majority of providers were male veterans; at this time, approximately half of the providers are non-veterans, and six are women.) Nine of these providers work under the auspices of a DVA/King County program collaboration; two providers (one in Skagit County, and one in Yakima) are RSNs.

DVA has a staff e-mail site where providers regularly discuss issues of concern. All staff attend yearly (or bi-yearly) meetings to discuss treatment methods and

presenting issues, as well as the annual regional Veterans Integrated Service Network (VISN) conference. In addition, three or four staff members attend a national conference each year, and DVA provides all contracted staff a budget for community education.

Consumer Involvement. Three of the contracted DVA providers are former customers of the program, and some other providers are currently on disability for PTSD. According to a DVA administrator, "They (the providers) craft the therapeutic environment in their communities."

DVA providers tailor their counseling methods to each client's stated and assessed needs. Some of DVA's contracted sites facilitate specialized groups that utilize peer counselors; some of the groups have themes (e.g., fishing, or woodworking). DVA mails out annual customer satisfaction surveys designed to provide ease of response and anonymity.

Budget. DVA has a current clinical services budget of $680,000 per fiscal year from the State General Fund, $250,000 from other sources (including King County's contribution to the DVA/county collaboration), and an additional 40 percent from Medicaid. (This excludes the mental health services provided in DVR's veteran homes.)

Observations. There are approximately 660,000 veterans in the state of Washington, which represents about 10 percent of the state's total population. The DVA clinical services program served about 400 veterans each year when it began in the early 1980s, and served over 1400 veterans in 2005. It is expected that the number of veterans served will continue to climb as troops return from the Iraq War.

Common Themes

Both OSPI and DVA serve large numbers of state of Washington citizens (1.2 million and 660,000, respectively), and estimate that between one third and one half of individuals in their population are dealing with some type of mental health disorder. OSPI directs its limited mental health dollars to assist students in moving past roadblocks to learning, while DVA uses its yearly budget to assist veterans in moving past roadblocks to functioning in civilian life.

Programs within DSHS Serving Clients with Mental Health Disorders

The state of Washington has a variety of social service programs functioning under the "umbrella" of the Department of Social and Health Services (DSHS). The organization and activities of one DSHS program area, the Juvenile Rehabilitation Administration, were described above. Seven other DSHS programs, each of which serves clients with mental health disorders, are outlined below. The Long-Term Care Ombudsman, a position that is funded by the Department of Community, Trade, and Economic Development (CTED), is also discussed below, as the Ombudsman is responsible for the well-being of many clients served by the Aging and Disability Services Administration (ADSA).

Division of Developmental Disabilities (DDD)

Policies. The Division of Developmental Disabilities (DDD) serves adults with developmental disabilities only. (Children with developmental disabilities are served through the Children's Administration, described below). The current DDD policy regarding developmentally disabled individuals with mental health disorders was formalized in 2000, and is the direct result of a settlement that grew out of a lawsuit concerning a DDD client's lack of access to appropriate mental health services.

There is a formal collaboration between DDD and MHD, funded by the Washington State Legislature. This is facilitated by a MHD/DDD cross-system committee, ongoing contact between MHD and DDD statewide coordinators, and the input of national experts (monitors) via written reports.

By policy, DDD clients can have a psychological evaluation and medication services, prevention/intervention services, hospital diversion alternatives, and multi-disciplinary treatment planning, if (and only if) they are at risk for hospitalization. A Certified Mental Health Professional (CMHP) makes the determination whether an individual is at such risk. Exceptions to policy, which require the DDD Director's approval, can occur if an individual presents community protection issues or if there is justification to pay for services not normally provided.

Practices and Organization. DDD serves 7,000 adults in Washington State. It is divided into six geographic regions. Each region has a licensed clinical psychologist, who completes functional assessments, and assists in support planning with RSN staff; Regional Mental Health Coordinators, who are a resource for non-mental health case managers; Case Managers for DDD clients with paid mental health services; Case Managers for DDD clients without paid mental health services; and Community Protection Case Managers, whose caseloads are limited to 30 due to the high-risk profiles of their clients. DDD operates five facilities which have psychiatrists and physicians on staff, including Rainier (in Buckley) and Fircrest (in Shoreline).

The primary focus of DDD's Adult Crisis Stabilization Services is the development of hospital diversion (alternative) plans for DDD clients. These are created in collaboration with the Mental Health Division and other agencies. The plans are an adjunct to, not a duplication of, Mental Health Division services. DDD clients must volunteer to participate in these alternative plans, due to the strict "harm to self, harm to others" guidelines in the state's Civil Commitment statues.

Adult Crisis Stabilization Plans may include the following components: *Diversion Beds* (DDD-certified residential settings that offer enhanced supports; there are 18 contracted beds in the state, in 3 different facilities, that are utilized for up to 21 days while a crisis plan is developed for an individual); *Crisis Prevention Contracts with RSNs*, which typically include prevention, intervention, and stabilization services; *Psychiatric Services*, contracted with ARNPs and psychiatrists for psychiatric evaluations and medication reviews; and *Residential Support Services* (residences owned and operated by DDD, that house up to four DDD clients).

Training. DDD staff are hired with the credentials required for the position (MD, psychology degree, MA, BA, etc.) in place. Staff psychologists offer training to new staff and residential/employment providers; this training is meant to be ongoing, but that is not the case at this time due to budget constraints. There is some cross-systems training with the Mental Health Division and other agencies provided to selected staff. In addition, DDD staff are involved in some statewide conferences, including the annual Washington Behavioral Health Conference.

Consumer Involvement. DDD has a strong stakeholder workgroup, Washington Protection Advocacy (WPAS) with a great deal of parent involvement. It is also one of the five agencies represented on the CTED council.

On a daily basis, DDD consumers are encouraged to be active participants in their plans and their care, and residential providers are always involved in the development of residents' individual plans.

Budget. DDD had a budget of $4,104,900 for fiscal year 2005, all of which came from the State General Fund.

ADSA Residential Care Services (RCS)

Policies. Residential Care Services (RCS), which functions under the auspices of Aging and Disability Services Administration, is responsible for the licensing of nursing homes, boarding homes (seven or more residents), and adult family homes (6 or fewer residents) statewide. They also license adult day health and adult day care facilities (some on-site in nursing facilities, and some off-site), and provide payment for respite care. RCS staff members evaluate providers to determine whether they

meet licensing standards. There are no pre-set state standards for facility staffing ratios; rather, RCS employees establish whether facilities have adequate staff to meet the "functional needs" of clients.

In Washington State, nursing homes must have 24-hour licensed skilled care. This is also mandated by federal policy regarding nursing homes; there is no federal policy related to boarding homes or adult family homes.

Practices and Organization. RCS staff members are not involved in direct service to clients. As noted above, they license nursing homes, adult homes, and day care facilities across the state. Evidence-based practices do not come into play, except to the degree that research establishes the level of care necessary for certain types of residents (those with Alzheimer's, brain injuries, etc.) and this research is integrated into licensing policy.

Training. There is statewide staff training for contracted providers on how to handle "difficult" residents, including those with mental health issues. In RCS's world, dementia and Alzheimer's disease are common problems; depression and conditions brought on by traumatic brain injury are also frequently encountered. Some of the homes that RCS licenses are certified to deal with brain-injured clients. There is no specialized training for dealing with Alzheimer's patients, but voluntary training is available to group home operators through RCS.

Consumer Involvement. As noted above, RCS does not have direct involvement with consumers. The residents living in facilities do have some "voice" in their care, but this occurs between the residents, facility staff, state caseworkers, and medical personnel, and does not involve licensing staff.

Budget. Half of the RCS budget is federal Medicaid dollars; the other half if from the State General Fund. Residents of nursing homes, boarding homes, and adult family homes are reassessed yearly, or any time there is a change in their condition. An individual's level of functioning determines the rate of Medicaid payment to the facility in which he or she lives.

Long-Term Care Ombudsman

Policies. The Long-Term Care (LTC) Ombudsman, an agency funded by the Department of Community, Trade, and Economic Development, responds to complaints from those who are eighteen years of age or older and living in a nursing home, a boarding home, or an adult family home in the state of Washington. State hospitals are not part of the Ombudsman's purview. Federal law SB6587—The Older American's Act—requires that it function as a separate agency.

Practices and Organization. The LTC Ombudsman has 14 regional offices and 400 staff members statewide. It responds to approximately 4,000 complaints per year. A spokesman for the agency reported that between 40 and 70 percent of the clients in nursing homes have either organic or situational depression; few of the agency's clients are served by the Mental Health Division or other mental health care agencies; and, in recent times, some RSNs have begun dropping contracts with adult family homes.

Training. The LTC Ombudsman staff members actively encourage facility staff to provide individualized, rather than "cookie-cutter", care. They are conscious that staff members in nursing homes, boarding homes, and adult family homes receive little training regarding their clients' mental health issues, and they are not tasked or funded to provide such training.

Consumer Involvement. Every effort is made to give clients who have registered a complaint a strong voice in their residential setting, their residential plan, and the manner in which their complaint is resolved. An LTC Ombudsman administrator made the point that "independent living" does not always work for the population the agency

serves, and some clients (particularly those with both physical and mental health issues) want to remain in a very structured setting.

Children's Administration (CA)

Policies. The Children's Administration (CA) is responsible for the provision of a variety of different services to children throughout Washington State. Per written policy, CA is not tasked with the provision of mental health services to children with mental health disorders. However, as many of the children served by CA have mental health disorders, the agency has developed practices, trainings, and methods of referral to address children's mental health needs.

Practices and Organization. The CA has offices in every county in Washington. They oversee Child Protective Services (CPS), which responds to complaints concerning child abuse and neglect; the state's foster care system (both family foster care, and out-of-family placements); adoptions (both family adoptions, and out-of-family adoptions); Family Reconciliation Services (which provides counseling and support services to family groups); and a variety of services to adolescents and young adults (18-21) who are "aging out" of the foster care system.

CA administrators and middle managers reported that over half of the children receiving services from the CA have a mental health diagnoses. Likewise, over half of youth "aging out" of the foster care system have mental health issues, and nearly 20 percent have three or more mental health diagnoses. According to a CA spokesman, the high incidence of mental health problems in the CA population is one of the primary reasons "we're relying more and more on evidence-based practices concerning children's mental health."

Training. Functional Family Therapy (FFT) is currently being used in every Family Preservation Services Center, in an effort to address the mental health of all family members, and all FPS staff members are being trained in FFT. CA intends to expand the use of FFT into the CPS arena. Foster care staff are currently being trained to do foster care assessments, which include a component regarding child and family mental health.

Consumer Involvement. CA staff members are encouraged to involve families and children in planning and plan implementation, insofar as possible. This approach is stressed at all agency trainings.

Budget. Thirty three percent of foster children receive Supplemental Security Income (SSI), and 98 percent of those children have mental health diagnoses. The foster care budget pays for mental health services for those children who need, but are not eligible for, formal mental health services.

Economic Services Administration (ESA)

The ESA is currently divided into six divisions. They are: the Community Services Division (CSD), the Information Technology Division (ITD), the Division of Child Support (DCS), the Division of Management Resources and Support (DMRS), and the Division of Employment and Assistance Programs (DEAP).

CSD administers cash, food, and medical assistance programs through a network of Community Service Offices (CSOs) and Customer Service Centers (CSCs) in six geographic regions. ITD manages information technology products and services to ESA staff statewide; DCS administers state and federal child support laws, including paternity establishment, and child support order establishment, modification, and enforcement; DMRS develops and monitors ESA's operating budget, and oversees ESA's business operations; and DEAP develops policies for the WorkFirst and Basic Food programs, as well as several other ESA programs.

ESA Community Services Division

Policies. The two programs in the Community Services Division (CSD) of the Economic Services Administration (ESA) most likely to serve clients with mental health issues are Temporary Assistance to Needy Families (TANF) and General Assistance Unemployable/General Assistance Expedited (GAU/GAX). Certain Community Services Offices (CSOs) also serve clients who are homeless and/or have dual diagnoses.

CSO staff members develop Individual Responsibility Plans (IRPs) for clients, which are social service plans outlining needed treatment, including mental health counseling and chemical dependency treatment. Under TANF regulations, the CSO is required to refer clients for medical treatment so they may reduce their need for public assistance. Although all TANF clients are eligible to be referred to mental health treatment, such referrals are not the CSO's primary focus, and clients are not required to participate in mental health treatment if it is made available to them.

GAU/GAX clients are eligible for state-funded medical care services. The statute governing GAU/GAX services specifies that GAU/GAX clients are entitled to Regional Support Network (mental health) services; the CSD itself does not provide such services. If it is determined that a GAU/GAX client would likely attain increased stability and become more employable by participating in mental health treatment, then they are required to participate in such treatment if they wish to receive their GAU/GAX grant.

Practices and Organization. The only information available concerning CSD practices and organization is the following description of the Seattle CSO. (CSOs are configured somewhat differently in different locales.) At the Seattle CSO, several agencies – DDD, DVR, CPS, and Adult and Aging—used to be co-located. They are now in separate locations, with only CSD and DSHS remaining at the original CSO site. There are 7 or 8 staff members on the CSO's "front line"; all staff work with all clients; and the majority of the clients have mental health issues. Six people on the staff are dedicated to assisting client in "walking through" the SSI process.

Training. TANF Case Managers are required to have a bachelor's degree in a financial field such as accounting. Social Workers are required to have a bachelor's degree in one of the social sciences, and a minimum of two years social service experience. Food assistance and medical staff members are required to have a bachelor's degree in some discipline.

Each CSD region is responsible for its own training. The division contracts outside for mental health training for its staff (such as the University of Washington in Seattle and Eastern State University in Cheney); there is a strong focus on training regarding co-occurring disorders.

Consumer Involvement. Some CSOs distribute annual customer surveys or ask for continuous client feedback; others do both. CSO clients can make choices from lists of available certified mental health providers.

Budget. According to a CSD Fiscal Administrator, CSD keeps information identifying the type of client (by age and gender, for instance) but not information regarding the reason for funding mental health services, or what particular type of service was offered. Therefore, CSD is unable to provide budget or expenditure information for mental health services. SCSD has an annual budget of approximately $4,000,000; 52 percent of GAU/GAX clients have a mental health issue documented in their incapacity evaluation.

Division of Alcohol and Substance Abuse (DASA)

Policies. The Division of Alcohol and Substance Abuse (DASA) provides chemical dependency services to clients statewide. The statute that governs DASA operations requires that DASA clients be assessed for signs of mental health issues, and be referred for treatment if it is determined that they are dealing with such issues. However, DASA does not provide mental health services and, in DASA policy, there are no exceptions which allow for payment of mental health services for DASA clients.

In some counties, grant monies or local funding streams provide DASA clients at least limited access to needed mental health services. In addition, DASA works together with the Washington State Department of Corrections regarding the oversight of Dangerously Mentally Ill (DMIO) offenders.

Practices and Organization. DASA's services are divided into four categories: adult services, adolescent services, pregnant and parenting women's services, and prevention services. A treatment manager and a prevention manager is employed in each of DASA's regions.

DASA operates *adult* inpatient facilities and recovery houses (all houses have a treatment component), as well as outpatient treatment facilities. The inpatient facilities and recovery houses are contracted with both counties and tribal governments; outpatient services are contracted with local providers. Some recovery support is offered; one month of aftercare is a routine part of outpatient treatment discharge plans.

DASA also operates Level 1 and Level 2 secure *adolescent* inpatient facilities, and has also certified certain school districts as treatment entities. It offers both inpatient and outpatient services to *pregnant and parenting women* and their families. (The outpatient component of the services is known as the MOMS Program, and is federally funded.) DASA's prevention activities include school mentoring programs; parent education programs; advocacy for change in local and state laws, ordinances, and policies; collaboration around substance abuse issues with a variety of non-profit organizations; and a developing focus on problem gambling.

A DASA spokesman estimated that 50 percent of DASA's current practices are evidence-based, and the percentage is rising. He pointed out that service and funding collaborations between chemical dependency and mental health agencies is acknowledged as an evidence-based "best practice."

Training. DASA case managers must have Chemical Dependency certification and a treatment background in social services. They are also encouraged, but not required, to get an ICRC prevention certification. New employees attend a one-week "Co-occurring Academy." Staff also have the opportunity to attend national and in-state conferences and trainings, including a Prevention Summit, and Annual Tribal Gathering, and ethics training.

Consumer Involvement. On a policy level, DASA administrators and supervisors sit on the on the Co-Occurring Inter-Agency Advisory Committee, the Citizen's Advisory Council, and the Co-Occurring Team at the National Policy Academy. On the client level, DASA staff members conduct focus groups with adolescent consumers and providers, and work with clients to develop individualized treatment plans. DASA trainings focus on motivational interviewing and client-centered services. Consumer satisfaction surveys of DASA clients are completed each year by the Department of Social and Health Services research department.

Budget. DASA mid-managers reported that DASA does not have any funding to provide mental health services to DASA clients. They also estimated that approximately 50 percent of DASA clients have mental health or co-occurring disorders.

Division of Vocational Rehabilitation (DVR)

Policies. The Division of Vocational Rehabilitation (DVR) assists individuals with functional loss (mental, physical, and psychological) to obtain and maintain employment. The agency is mandated by the state of Washington Rehabilitation Act (RCW…) to serve individuals by "order of selection." This means that individuals who meet four of the seven established functional loss criteria must be served first. Effectively, this means that the more functional individuals who would be eligible for DVR services are placed on a waiting list, and are constantly "bumped back" by less functional individuals coming into the system. Currently, there are approximately 12,000 persons on the waiting list.

Practices and Organization. As noted above, DVR assists individuals who have functional loss to obtain and maintain employment. An agency administrator stated that DVR staff members have about a 50 percent success rate in placing clients in appropriate jobs, but that this percentage would climb if DVR was not required to serve "the most significantly impaired" first. She estimated that at least 50 percent of current DVR clients have mental health issues, and 27 percent have a mental health disorder (or disorders) as their primary disability.

DVR has offices throughout the state. Agency staff members make frequent visits to clients' worksites. The agency is in the process of shifting from supporting clubhouses for the mentally ill to supporting activities that help people with mental health issues to achieve steady employment. This decision is based on research that says involvement in gainful employment promotes mental health.

Training. According to a DVR administrator, "DVR staff are trained to the needs voiced by consumers". DVR counselors must have a Master's degree in Rehabilitation Counseling. Continuing education is required, and monies for this are provided by a federal grant; tuition reimbursement is provided for formal continuing education. . New DVR staff are required to attend a two-to-three week Rehabilitation Academy, which is spread out over a period of several months. There is a great deal of additional training offered, on an ongoing basis, in DVR offices throughout the state.

Consumer Involvement. Each DVR client has a work plan. The client's input (for instance, in terms of type of work, work schedule, work location, special accommodations) is solicited. There is a strong agency focus on consumer-informed choice and tailored vocational goals. Clients are very much involved in, and influential regarding, their individual work plan.

Budget. DVR has a current budget of $53,000,000 per fiscal year. 78.7 percent of the budget is federal (Medicaid) dollars, and 21.3 percent of the budget comes from the State General Fund.

Medical Assistance Office of Medicaid Systems and Data

Policies. DSHS' Medical Assistance (MA) distributes Medicaid funds to nearly one million eligible state residents each year. Community mental health services are one aspect of Medicaid funding; MAA has no hand in payments for services in state mental health institutions.

For individuals who meet Regional Support Network (RSN) criteria, mental health services are billed and paid for via their local RSN; individuals who do not meet RSN criteria can receive up to twelve hours of psychiatric services per year.

MA is in the process of implementing the ProviderOne system, which will consolidate Medicaid payments across systems.

Practices, Organization, and Consumer Involvement. As noted above, MA offers no direct services to clients.

Budget. Of the mental health services that are reimbursed by MA, 50 percent are paid for with federal monies, and 50 percent are paid out of the State General Fund. The total MAA yearly budget for psychiatric services (in 2005) was $3,251,882; the yearly budget for medication review (in 2005) was $1,908,419.

Common Themes. Although none of the agencies described above was originally created to serve individuals with mental health disorders, agency administrators and middle managers across the DSHS system speak of ongoing (and ever-increasing) involvement with clients who have such disorders and are clearly in need of mental health care. There is a consensus that either increased funding for mental health services needs to be provided to each agency interacting with this population, or access to mental health services provided by the Mental Health Division has to be increased and improved.

Agencies Offering Prevention or Early Intervention Services to Clients with Mental Health Disorders

Four Washington State agencies are included in this section because, in regard to mental health, their primary focus is on either prevention or early intervention activities. The administrators of these agencies made it clear that, while they are not specifically mandated to serve clients with chronic and severe mental illness, they believe their agencies are invested in activities that will positively impact the mental health of all of Washington State's citizens.

Department of Community, Trade and Economic Development (CTED)

CTED is a Community Action Agency which serves over 200,000 persons annually by funding 31 agencies across the state. It is grouped into six divisions: Housing, Community Services, Local Government, Economic Development, International Trade, and Energy Policy. This agency does not diagnose, treat, or label mental health disorders, with the exception of contracting for therapy for victims of sexual offenses and other crimes through Crime Victims' Advocacy (CVA) program. Rather, it funds community projects that encourage consumer voice and tailored services.

CTED has branches in every county in Washington, and several branches in the state's larger counties. Some of CTED's primary activities are the funding of food banks (which serve over one million clients annually), the funding of the state Long-Term Care Ombudsman (discussed under the DSHS agency section), the funding of advocacy and treatment for crime victims, and the funding of preschool programs for children at risk. Each year, between 30 and 60 percent of CTED's annual budget goes to its housing program.

To underscore the diversity of programs funded by CTED, three CTED operations—Housing, Crime Victims' Advocacy, and Early Childhood Education Assistance Program—are described below.

CTED Housing Division

Policies. A percentage of the Housing Division's funding is federal (see "*Budget*" section, below). A Housing Division administrator offered, "The feds have a high interest in serving people with mental health concerns. However, the funds go primarily to 'bricks and mortar'—rehabbing facilities, rental assistance, and so on." She went on to explain that, historically, a large amount of federal Housing and Urban Development (HUD) money was spent on services for the mentally ill, but at this time less is spent for services and more is spent on housing. HUD does not prohibit grantees from spending funds on services, but it takes "points" away for doing so in the following grant cycle, so the grantee is at risk to lose funding. According to Housing Division staff, the ways that monies from the State General Fund can be used is "wide open" compared to federal funds.

The priorities for the Housing Division are finding or creating stable housing for the homeless, individuals with "special needs" (including mental illness), and low income families. Federal guidelines specify that "homeless" means a person has been homeless for one year, or homeless three or more times within the last four years.

Practices and Organization. The Housing Division does no direct service. It provides funding to agencies statewide so that they can develop, rehabilitate, and operate housing for priority populations (the homeless, those with "special needs," and low-income families).

Division staff noted that many of those provided with housing have multiple disabilities, often including mental illness, substance abuse, and physical impairments.

Consumer Involvement. According to Housing Division administrators, consumers impact agency policy to the extent that consumer advocates drive policy that favors the placement of individuals with mental health disorders in stable housing. There is little consumer involvement in Housing Division processes: to the extent that an individual meets certain criteria, an effort will be made to provide him or her with no- or low-cost housing.

Budget. As noted above, the Housing Division provides pass-through funds to organizations that provide homes and shelter to designated disadvantaged populations. The total annual budget is $17,500,000. Of this amount, 90 percent comes from the State General Fund and the remaining 10 percent comes from federal grants (HUD monies). Housing Division staff estimated that approximately $1,500,000 of the Division's yearly budget is spent on the chronically homeless, many of whom are mentally ill.

CTED Office of Crime Victims' Advocacy (Community Services Division)

Policies. The Office of Crime Victims' Advocacy funds 54 programs statewide that offer services to victims of various crimes, and has responsibility for oversight of those same programs.

Practices and Organization. OCVA does no direct service. As noted above, it funds 54 different programs statewide, and is responsible for accreditation, monitoring, and review of the programs it funds. (OCVA staff noted that they are about to begin a new data system for all contractors that will be much more comprehensive than the system utilized to date.)

The programs OCVA funds provide many different services to crime victims, including therapy; collaborative efforts with schools, CPS, criminal justice organizations, and medical personnel; and domestic violence programs. Therapy for victims of sex offenses (who often suffer from PTSD and depression) is the service most frequently offered; 64 percent of those victims are children. In 2005, 9,728 new OCVA clients received one or more advocacy, crisis intervention, or therapy services; of that number, 20 percent received sexual assault therapy.

Training. All of OCVA's contracted providers must be properly licensed. The type of licensing varies, as OCVA contracts with clinical psychologists, MSWs, and individuals with other professional degrees. It does not provide ongoing training to its contractors.

Consumer Involvement. OCVA clients have a strong voice in their treatment plan. However, those with DSHS medical coupons can only be served by community mental health centers, and those centers do not generally do trauma-focused therapy and are not at all prepared to provide children's trauma-focused therapy. An OCVA administrator stated, "These clients are in need of quick and quiet interventions, and ongoing access to follow-up. The atmosphere at (community mental health centers) is a poor fit for them, the adults and the children, too."

Budget. OCVA's total yearly budget is $3 million. Of this amount, 60 percent comes from the State General Fund, 15 percent each comes from the State Violence Reduction and Drug Enforcement Fund and the Public Safety and Education Fund, and 10 percent comes from federal Medicaid monies.

CTED Early Childhood Education Assistance Program (Community Services Division)

Policies. Per policy, the Early Childhood Education Assistance Program (ECEAP) must serve all kids in the program, and their families. A DECA (early childhood mental health) assessment is mandated for every child in the program, and any children with presenting mental health problems must be referred for counseling.

Practices and Organization. ECEAP has 33 contracted facilities statewide, including a facility in Olympia where Headstart and ECEAP are combined. The program, which is modeled after Headstart, has developed partnerships with:

- Schools, colleges, and churches (all of whom offer classrooms)
- Medical/dental/mental health providers (some on-site)
- Volunteer groups
- And Tribes

It provides early (preschool) education, health and nutrition education, and family support to 18,000 students and their families, and strongly encourages parental involvement in ECEAP activities.

Training. ECEAP staff members are trained to complete, and interpret, DECA assessments. They are also asked to note, report, and respond to indicators of mental health problems in the student population, with particular attention to symptoms of attachment disorder, conduct disorder, and childhood depression.

Consumer Involvement. ECEAP is a family-need driven program. According to ECEAP program managers, the profile of the ECEAP families is changing. In the past, many ECEAP students were being raised by single women on welfare. This was a problematic situation in many ways, but it did allow mothers time to interact with their children in the preschool setting.

Presently, 80 percent of the parents of ECEAP students are working poor; 50 percent of the ECEAP students live in one- or two-parent households where all adults are working; and many families get food stamps and WIC, but no other form of public assistance. This leads to a situation where students get less parental attention, both at home and in the school setting. Adjustments (in terms of staff, hours, and services) need to be made to better serve families, but the current budget will not accommodate these changes. As one ECEAP employee sees it, "We fail not because our focus (on kids, and families) is wrong, but because we lack resources…It's simple; if the family isn't well, the child can't be well."

Department of Health (DOH)

Policies. DOH does not provide any direct services, but does fund a variety of programs statewide that provide direct mental health-related services or access to mental health evaluation or treatment. In addition, DOH grants support the planning and evaluation of programs designed to prevent mental health disorders, or to provide early intervention for persons dealing with such disorders. DOH priorities include environmental health, "medical home" initiatives, inter-conception care (care between pregnancies), healthy childcare (with attention to maternal depression and maternal/child bonding), HIV client services, and injury and trauma prevention.

Practices and Organization. In Washington State, the public health system was designed with the idea that there would be strong local authority. Currently, the state has 35 local health jurisdictions. Of these, approximately one third are health and social services combined, and three to five are exclusively Board of Health. Some smaller counties have multi-county jurisdictions, and King County and the City of Seattle have combined jurisdiction.

DOH supports some programs in each of the public health jurisdictions that serve the entire state, including the Public Health Laboratory, The Center for Health Statistics, Shellfish Safety, certifications for professional groups providing medical/social services to the public, and immunization programs. Beyond these comprehensive programs, it provides grant monies to a wide range of groups and agencies throughout the state.

Council for the Prevention of Child Abuse and Neglect

Policies. The Council for the Prevention of Child Abuse and Neglect is a state agency that operates under the auspices of the Office of the Governor. It serves the entire population of the state of Washington, and principally funds community-based programs dealing with child abuse and neglect.

Practices and Organization. The Council's focus is on the prevention of child abuse and neglect and the promotion of child well-being. It provides community-based programs with funding to produce outcome evaluations, train staff, and develop interventions that support children's social and emotional development (such as mental health assessments and treatment, family therapy, and child care centers). In addition, the Council contributes to conferences that address issues related to child abuse and neglect, funds public awareness campaigns regarding child abuse and neglect, and supports public policy initiatives that positively impact the issue of child abuse and neglect.

Current recipients of Council funding are the Healthy Start (preschool) and Wonderland (birth-to-three) programs in King County; the PTIC program (three-to-eight) in Whatcom County; attachment therapy at Mary Bridge Children's Hospital in Tacoma and Martin Luther King Center in Spokane, and the Ages and Stages screening tool. The Council is close to implementing a statewide post-partum depression campaign, and has an across-the-board priority of promoting strong families.

Consumer Involvement. The Council has no direct involvement with consumers, but a Council administrator stated, "There is a great deal of (consumer) involvement at the service level…we look at this carefully when we make funding decisions."

Budget. The Council has a yearly budget of $1.2 million. Half of this amount is federal dollars (from Medicaid), and half comes from the State General Fund.

ESD Governor's Committee on Disability Issues

Policies. The 39-member Governor's committee, which functions under the auspices of ESD, exists to serve two primary groups of state of Washington residents who are Social Security beneficiaries: 1) dislocated adult workers, and 2) disadvantaged youth who have either a disability or a low family income. (Exceptions can be made to accommodate youths under 16 who cannot qualify for Social Security.)

Practices and Organization. The Committee has responsibility for the operation of two distinct programs. The first is the Department of Labor-funded "Navigator" program. This program employs "Navigators" who work with communities to build the communities' capacity to employ disabled workers. Navigators are currently employed in 9 of 12 ESD regions. (Similar work is already funded in the other three ESD regions.)

The Navigators function as advocates for individual disabled workers, and as liaisons to various community groups. They have linkages with K through 12 special Education programs, and do orientation sessions with staff from school districts. They also "mentor" with local employers, take disabled adolescents on "field trips" to ESD offices (to expose them to their employment and job service options), and develop community councils and school-to-work programs. Whatever the particular project, the Navigators focus heavily on the sustainability of the programs and services they implement.

The Committee also operates the Workforce Investment Act (WIA) program, which serves individuals who meet the American Disabilities Act definition of "disability" and are seeking employment. WIA Benefit Specialists travel to ESD "One-Stop" offices statewide to assist clients with disabilities in creating individually-tailored work plans that take into account where (in what field, in what setting) and how often (how many days, how many hours per day) the client wants to work.

A Committee spokesman estimated that 30 percent of the clients served by the two programs described above have some type of mental health disorder. He explained that accurate statistics have been hard to obtain, as many individuals served by the programs are afraid to admit to mental health issues for fear of losing current or potential employment.

Training. Five of the nine Navigators are certified as vocational rehabilitation counselors, and two others are employees of community mental health programs. The Social Security Administration pays for ongoing training activities for all of the Committee's contracted staff. If the training is offered in Washington, all of the Committee's staff attends; if the training is out of state, one employee attends and then "reports back" to other staff.

Consumer Involvement. Whether they are served by the Navigator program or the WIA program, clients have a strong voice in the development of their work plan. Some, but not all, of the communities served by the two programs have community boards with members from local disability organizations. The Committee itself has 39 members who represent all facets of disability; some of the members are themselves disabled.

Budget. The Navigators program is federally funded; a two-year grant will soon expire, and Washington State has submitted for grant monies to continue the program. The WIA program receives 84 percent federal funding; the remaining 16 percent comes from the State General Fund. The program is currently in the sixth year of a five-year grant (it is on extension); Washington has submitted for grant monies to continue the program.

Family Policy Council

Policies. In 1992, the Washington State Legislature enacted the Family Policy Initiative (RCW 70.190), which created the Family Policy Council (FPC) to design and carry out principle-centered, systemic reforms to improve outcomes for children, youth, and families. The FPC is comprised of the heads of five state agencies dealing with children and family services, four members of the Legislature, and a representative from the Governor's Office.

In 1994, the Legislature passed the Youth Violence Reduction Act, which authorized development of grassroots organizations called Community Public Health and Safety Networks across the state. The Networks' mandate is to improve seven "problem behaviors": child abuse and neglect, youth violence, youth substance abuse, teen pregnancy, domestic violence, school dropout, and teen suicide. The Legislature established that each Network's board is to have 13 members (known as "non-fiduciary members") who do not make their living from the social service delivery system, and 10 members (known as "fiduciary members") who do make their living from that system.

There are currently 36 Networks, including five Tribal Networks. They range in size from 200 to 550,000 people, and cover every area of the state. The Networks (whose boundaries are set by the citizens within each Network, rather than the state) have the authority to support the development of new programs within their purview; review existing programs, laws, and regulations; and recommend changes in state and local policies.

Practices and Organization. The FPC manages interagency agreements with each of the Networks, provides technical assistance and training to increase the capacity of local committees, and screens and endorses policy recommendations and promising practices developed by Networks. The Networks plan and implement specific treatment and service strategies that will help children in their area, utilizing evidence-based practices. They analyze which needed services are absent, and which services are duplicated, in their area. They then promote the changes, involving both professional and "natural" supports, which they believe will best serve their community's children.

Training. As noted above, one of the FPC's primary responsibilities is to provide training to the Networks in order to increase the capacity of local communities to care for their children.

Consumer Involvement. The concept of ongoing and meaningful consumer involvement is implicit in the design of the Networks—their basic structure (the members decide what the boundaries of the Network are, and what issues they will address), their boards (which include professionals, but are weighted on the side of "laypersons"), and their focus on informal as well as informal supports for children.

Budget. The FPC's 2001-2003 budget was $6.7 million. Nearly 87 percent of the budget went to the Networks in the form of pass-throughs, statutory awards for exceptional results, and direct supports (such as training and technical training) to communities. Networks receive a base amount from the FPC, plus formula funding based on population served and documented rates of problem behaviors.

Common Themes. Although the agencies outlined above are focused on service to differing populations, they all believe that appropriate supports—such as housing, employment, counseling—at the "front end" will go a long way toward preventing or mitigating mental health disorders and creating quality of life for their clients. They are "of a mind" in their frustration about society's (and Washington State's) tendency to wait until a person is debilitated before offering support, and share the view that this approach is extremely shortsighted and damaging to individuals, families, and communities.

Chapter 7 | Washington State Matrix

JULY 2006

PRELIMINARY | Still Under Review

Alignment between

THE NEW FREEDOM COMMISSION TRANSFORMATIVE PRINCIPLES AND GOALS

and

WASHINGTON STATE TRANSFORMATION RESOURCES, GAPS, AND NEEDS

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The President's New Freedom Commission on Mental Health met and collected information for a year in 2002. It produced a final report in July of 2003, which concluded that:

> ". . . for too many Americans with Mental Illness, the mental health services and supports they need remain fragmented, disconnected and often inadequate, frustrating the opportunity for recovery. Today's mental care system is a patchwork relic—the results of disjointed reforms and policies." (From the Commission's introduction letter)

The Commissions' vision is for a "fundamental transformation" . . . beyond ". . . yet another piecemeal approach to mental health reform." It states that:

> "Successfully transforming the mental health service delivery system rests on two principles:
>
> - First, services and treatments must be consumer and family centered, geared to give consumers real and meaningful choices about treatment options and providers – not oriented to the requirements of bureaucracies.
> - Second, care must focus on increasing consumer's ability to successfully cope with life's challenges, on facilitating recovery, an on building resilience, and not just on managing symptoms.
>
> Built around consumers' needs, the system must be seamless and convenient." (page 5)

The commission then presented and discussed six goals for this transformation, based on the above principles and the necessary "seamless" infrastructure.

"The goals are intertwined. No single step can achieve the fundamental restructuring that is needed to transform the mental health care delivery system."

In the first part of this report we described the structure and resources of Washington State's system of care—the current fragmented state of the system. In the second part we investigated how various groups of people and state agencies saw the system and its needs, from their different perspectives—many identified common needs, some identified unique ones.

As the research for this report demonstrates, Washington State consumers, agencies and providers identified the same sorts of needs and gaps found by the New Freedom Commission. The table below, repeated from Chapter 1, summarizes the relationship between the New Freedom Commission goals and the major themes found in Washington State. In the rest of this chapter, we define the "Matrix" required by SAMSHA: the policies, practices, training, organization, budget, and data resources, needs and gaps around each of Washington's major themes. This material will help guide the development, monitoring, and evaluation of the Washington State Plan.

Gaps in the State's Mental Health System: Six Perspectives

	Washington State Needs Assessment					
	Gaps by Perspectives					
Washington State Gap Areas Organized Under the President's New Freedom Commission on Mental Health Goals	UNDER-SERVED CONSUMERS	SERVED CONSUMERS	AGENCIES	MENTAL HEALTH DIVISION	RSNS	PROVIDERS
GOAL 1: Mental Health is Essential to Overall Health						
• Access to services	✓		✓	✓	✓	✓
• Stigma and public knowledge	✓	✓	✓	✓	✓	
GOAL 2: Mental Health is Consumer and Family Driven						
• Service choice and quality	✓	✓	✓	✓	✓	✓
• Jobs, school, and housing help	✓	✓		✓	✓	✓
• Care in jails/prison, and transition to community care	✓		✓		✓	
• Service integration and coordination	✓	✓	✓	✓	✓	✓
• Consumer voice	✓		✓	✓	✓	
GOAL 3: Disparities in Mental Health Services are Eliminated						
• Access to culturally and linguistically appropriate services	✓					
GOAL 4: Early Mental Health Screening, Assessment and Referral are Common Practices						
• Early intervention and screening	✓		✓	✓	✓	✓
• School and primary care collaboration	✓		✓	✓	✓	
GOAL 5: Excellent Mental Health Care is Delivered and Research is Accelerated						
• Service quality			✓	✓	✓	✓
GOAL 6: Technology is Used to Access Mental Health Care and Information						
• Integrated health records			✓		✓	✓
• Health information on website		✓	✓			

Mental Health is Essential to Overall Health

ACCESS TO SERVICES

Overview

Access to mental health care in Washington State is limited by several dimensions: diagnosis, functional disability, and health plan coverage. There are essentially three types of coverage:

1. Full Service MHD Consumers: Consumers enrolled in the Regional Support Networks, whose services are funded through the Mental Health Division. This group of consumers must meet MHD/RSN "access to care" standards, which means that the consumer has to have the "right" diagnoses and fairly severe functional limitations from that diagnosis.

Access problems for these consumers

- This group has two funding streams which cannot be mingled: Medicaid capitated dollars, and state-only dollars for persons not on Medicaid. In practice, the Medicaid client can almost always be served, but the state-only dollars run out before everyone can be reached.
- RSNs cannot serve people who are not experiencing functional limitations; hence early intervention is not possible, no matter what the prognosis without treatment.
- Only the most severe of the RSN consumers are entitled to individual counseling through the RSNs.

2. "Partially Served" Health Care System Consumers: Consumers who have any DSM diagnosis which makes treatment medically necessary, and who have state-funded health care coverage, are entitled to limited mental health services from the private health care sector. These health plan benefits generally included unlimited medication and medication management, 10 to 12 counseling visits a year, and some inpatient psychiatric care.

Access problems for these consumers

- Payment levels for psychiatrists have made medication management very difficult to find for many consumers across the state.
- Although some evidence-based treatments can be completed in ten or twelve visits, many cannot (for example, behavioral activation for depression takes on average 18 to 20 visits).
- Many families with children fall into this group: there are no services to families funded through this program. The long-term effects of the mental illness of parents on the children's mental health are not dealt with.

3. "Not Served" Consumers with No Health Care Coverage and No RSN Eligibility: Consumers who do not have state or employer funded health plans AND do not meet RSN Eligibility are not entitled to any state-funded mental health care. If they receive care or medication, it is through charity or locally funded services, or through service which is funded within other agencies which are also serving them. (See chart on page 18). There is no statewide behavioral health resource for them.

Access problems for these consumers

- Paying for medications and medication management and monitoring.
- Obtaining any kind of consistent counseling.
- Continuity and consistency of care is unavailable.
- Quality assurance and evidence-based practice are unlikely.

In practice, several groups of consumers are particularly likely to be unserved or underserved by this patchwork system. These include the homeless, people with co-occurring physical or chemical dependency problems, the at-risk children of adult consumers, and working-age adults without dependent children (unless they become completely disabled by their mental illness).

Access to Services

POLICIES	GAPS AND NEEDS	JUSTIFICATION
Chapter 74.09 RCW—Establishes medical services, including behavioral health care, for recipients of Medicaid as well as general assistance and alcohol and drug addiction services. *Chapter 71.24 RCW*—Establishes community mental health programs through county-based regional support networks that operate systems of care.	All Groups: Need a system of care that is simple and transparent across funding sources, so that people receive seamless behavioral health care. Partially Served: Need to increase the counseling allowed under the underserved group (non-RSN) to encourage earlier intervention and treatment, so that functional limits can be reduced rather than exacerbated. Not Served: Need a consistent behavioral health benefit at lower levels of care need, to encourage earlier intervention and treatment, so that functional limits can be reduced rather than exacerbated.	Current access policies: • Leave many consumers unserved (Chapter 2) • Lead to high levels of psychiatric inpatient care and lower levels of functioning by "requiring" functional limits as a condition for obtaining services from the MHD/RSN (Chapter 5) • Create provider and RSN inefficiencies and continuing moral dilemmas (Chapter 5) • Forces other agencies and local communities to fund mental health services in house, leading to further fragmentation and lack of transition services (Chapter 6) • Keeps underserved and unserved consumers from getting the care they need when they need it; creates enormous barriers to getting help (Chapter 3)

PRACTICES	GAPS AND NEEDS	JUSTIFICATION
Agencies create and fund services for the "worse off" among their clients (Chapter 6 Chart)	All groups need a set of coordinated practices that makes it possible for multiple payers to contract for access to a consistent set of mental health services.	Care that is not consistent and seamless is instead inefficient and overlapping – and the consumers get and lose access to care in a bewildering fashion that exacerbates their problems (Chapter 3)

TRAINING	GAPS AND NEEDS	JUSTIFICATION
There is training within the MHD for RSNs to enforce the RSN "access to care" standards.	There is no training or on-line information for consumers themselves, telling them how to get help – and when to seek it. There is no training for "gatekeepers" in other agencies as to the current rules for obtaining service.	There is little benefit in providing more training on the current system of access to mental health services. However, a transformed system will require new training targeted both to consumers, their families, the general public – and to gatekeepers and possible referral sources.

ORGANIZATION	GAPS AND NEEDS	JUSTIFICATION
Organizational fragmentation of access rules for the partially served and unserved is the norm in Washington State government. Tribes and the federal government also provide mental health services to low-income state residents through VA & Medicare.	GAP: There is no way in the current fragmented structure of service provision for anyone to refer a person for medically necessary psychiatric screening and treatment with any assurance that treatment will happen.	See comments throughout Chapter 6 from the agency perspective. See Chapter 3 for the perspective of the underserved clients. See Chapter 5 for the frustrations of the RSNs and providers. Needed Organizational Decision: If state services are simplified and expanded for the unserved and partially served, should that expansion be provided through the RSNs and the MHD, or through the private sector mental health professionals?

CONSUMER VOICE	GAPS AND NEEDS	JUSTIFICATION
Consumers have some voice in the MHD/RSN system. There is no explicit MH consumer voice in other agencies that are providing services to the underserved – although those agencies often have client representation generally.	Unserved and underserved consumers are not heard by most people making decisions about services. Their voices MUST be the main ones included in discussions of access. It is their voices and the agency voices that called out this theme most clearly.	See Chapter 3.

BUDGET	GAPS AND NEEDS	JUSTIFICATION
System is designed to expend scare service dollars only on those whose need is most severe and acute – or on those whose care is matched by the federal government.	Need new dollars to expand service for the partially served and unserved, and to treat mental illness as it first is diagnosed rather than once it has become chronic. Need new dollars to expand services to families and children Need new arrangements for funding to collect matching dollars whenever possible.	Earlier and more timely intervention in mental illness, and better services to families and children, should result in cost offsets in three areas: • Reduced medical expenditures • Reduced use of psychiatric hospitals • Reduced use of jails or prisons HOWEVER, new dollars are needed because those cost offsets will take time to occur, and "capturing" them explicitly in state budgets will be quite difficult in the case of the state hospital and prisons, and almost impossible with regard to jails and community hospitals.

DATA	GAPS AND NEEDS	JUSTIFICATION
Presently the data on who is served with what services is buried in many different payment and encounter data systems.	Need to unduplicate persons served and services received, and match to recovery outcomes, so that we can answer the following questions for Washington State: • How many of the low-income people who need services are getting served? • How well are people transitioning from one service system to another? • How many consumers are receiving evidence-based services? • How are consumers doing in their recovery?	The charts in Chapter 2 "unduplicate" much of the mental health care provided within DSHS. However, even within DSHS, we have not yet been able to sort out the mental health services contained within the medical encounter data, and only partially been able to pull them from the other DSHS databases (for example, the funds Vocational Rehabilitation spends on mental health assessments for their clients have not been included). Other state agencies are equally problematic. Here the justification is the fact that we cannot, yet, answer the questions under "gaps" and "needs"

Mental Health is Essential to Overall Health

STIGMA AND PUBLIC KNOWLEDGE

Overview

There is good opportunity for the transformation grant to develop a sustainable stigma reduction campaign – because little is happening at present in Washington.

Consumers say:

"My husband was physically abusive to our son, and he was in danger, but it still took an act of God to get him back because I had been in a mental hospital for 13 days."

"People say derogatory things about mentally ill people all the time. It never stops."

POLICIES	GAPS AND NEEDS	JUSTIFICATION
There are no official policies assigning anyone in state agencies responsibility for stigma reduction or for general education of the public (other than the Mental Health Transformation Grant).	GAP: A policy and associated actions are needed.	More than half of the served consumers say stigma has affected them (Chapter 4) The underserved are also deeply affected by stigma (Chapter 3) RSNs discuss the impact of stigma on preventing people from seeking services and making it difficult for consumers to find employment (Chapter 5). Other agencies agree (Chapter 6)
PRACTICES	**GAPS AND NEEDS**	**JUSTIFICATION**
MHD has given internal responsibility for stigma reduction and public education to the Office of Consumer Affairs in its seven year strategic plan.	GAP: So far there are not many practices to describe. A plan and actions are needed and are indeed underway.	See above.
TRAINING	**GAPS AND NEEDS**	**JUSTIFICATION**
There is at present no consistent training on stigma reduction or appropriate public education.	GAP: Targeted training for "gatekeepers" in schools and law enforcement to reduce stigma and enhance knowledge might be useful in improving outcomes.	See above.
ORGANIZATION	**GAPS AND NEEDS**	**JUSTIFICATION**
No one is responsible and someone should be. DOH with its general public health oversight role is one possibility. MHD knows the content area. The Governors Disability Task Force might be a third possibility.	GAP: Over the long term, is anyone to assume responsibility for stigma reduction and public education? It might be useful to think even at these early stages about sustainability: where should the oversight for stigma reduction "live"?	See above.
CONSUMER VOICE	**GAPS AND NEEDS**	**JUSTIFICATION**
Consumer voices are speaking and being heard, but no one is in charge of actually doing anything yet.	NEED: Consumers and their families should be involved in designing, reviewing and approving campaign.	They know the prejudices and their impacts. They can also assess the impact of the campaign on the consumers themselves.
BUDGET	**GAPS AND NEEDS**	**JUSTIFICATION**
No dollars are spent yet.		See above.
DATA	**GAPS AND NEEDS**	**JUSTIFICATION**
Baseline data on impact of stigma on consumers now exists in the MHD consumer survey. Suggest that be continued; would be a good measure of success.	GAP: There is no baseline measure of public perception itself or the perceptions of gatekeepers.	Useful to measure baseline perceptions before MHT attempts change, by adding a few questions to an ongoing survey at low cost.

Mental Health is Consumer and Family Driven

SERVICE CHOICE AND QUALITY

Overview

Mental health service choice for Washington State consumers is quite limited.

- Accessing any mental health services is a problem for the unserved consumers and families, let alone being able to choose their services.
- For the partially funded, the availability and quality of services are deeply limited by the limitations on counseling services within the current health plans. A 12 visits limit each year makes evidence-based counseling practices such as cognitive-behavioral for anxiety or behavioral activation treatment for depression or dialectical behavior treatment for borderline personality impossible to obtain, even if a provider who would accept Medicaid reimbursement rates were to be found. Family services are not funded at all under the health plans. In policy, medication and medication management for this group are unlimited, but in practice they are very difficult to obtain because of the payment limitations on psychiatric care.
- For the MHD consumers funded by Medicaid, service choice is limited by policy through the "level of care standards." (See Chart in Chapter 2 for details).
- For the MHD consumers who are not funded by Medicaid, service choice is limited as well by lidded funding.

Some service areas are particularly lacking.

- Even consumers who are successfully receiving mental health services report that their services have not assisted them in such key recovery elements as getting or keeping jobs and housing
- Peer and consumer-led services such as clubhouses and peer groups are inconsistently available even to MHD consumers, let alone to the unserved and partially served
- Family counseling services and services to children who are troubled but do not have thought disorders
- Psychiatric rehabilitation services

Mental health service quality: Mental hospital quality assurance is managed partly though federal and state audit and certification processes. However, outpatient service quality assurance at the provider level, based either on specific consumer feedback, on fidelity to care standards, or on consumer outcomes, is limited and inconsistent.

There is a good deal of research within Washington State universities on evidence-based treatment. For example, behavioral activation and cognitive behavior therapy were both developed by members of the Psychology Department at the University of Washington. And the recently funded CHAMPS center at Harborview Hospital is focused specifically on developing and spreading evidence-based practices for consumers with co-occurring disorders, either chronic physical conditions or diseases, or chemical dependency.

However, except in Juvenile Rehabilitation and the recent Children's Mental Health Initiative, there has been little attention paid at the state level to developing any incentives to encourage the adoption of evidence-based practices by providers or to assess the quality – based on outcomes – of the services already being provided.

Service Choice and Quality

POLICIES	GAPS AND NEEDS	JUSTIFICATION
Service choice is limited by benefit design and medical necessity for the partially served, and by the minimum modalities for Level 1 and Level 2 consumers in the RSN contracts for the MHD consumers. Mental Health Parity – SHB1154 – passed during the 2005 Legislative Session, with a four year phase-in. Requires private insurers to cover mental health treatment comparably to physical health treatment.	Some services are simply not available, or are only available in some areas, including: • Recovery oriented services designed to assist consumers in getting and keeping jobs, housing and needed work training • Peer and consumer led services • Family counseling • Psychiatric rehabilitation training, licensing and certification	Chapter 4-Over half of served consumers report job and housing problems. Chapter 3-Homeless clients have great difficulty getting services. Chapter 5-Only about 15% of MHD consumers of working age are earning wages. Chapter 3-Family counseling is deeply needed.

PRACTICES	GAPS AND NEEDS	JUSTIFICATION
Service quality for inpatient care is managed through accreditation, safety assessments, and consumer surveys. Service quality for community care is not consistently assessed.	NEED OUTCOME-BASED QA: Need consistent method for assessing the quality of outpatient services, which encourages providers to adopt evidence-based practices and encourages the spread of good local innovations.	See Chapter 5 and Chapters 2 and 3, which discuss care problems from the mental health specialists and consumer points of view.

TRAINING	GAPS AND NEEDS	JUSTIFICATION
Within the hospitals, training on internal quality assurance: Training on the EBPs from the DSHS Juvenile Rehabilitation Administration and the Children's Mental Health Initiative	CHOICE: Consumers need information – perhaps training – on quality and kinds of services available, to assist them in choosing. Providers themselves are investing in training on EBPs (see Chapter 5). Can the state as a funder find a way to reward this? May need to fund some training on chosen EBPs	The justification for more training depends on how the MHT decides to approach EBPs.

ORGANIZATION	GAPS AND NEEDS	JUSTIFICATION
Washington Institute of Mental Illness and Training: Eastern and Western Seven state Universities with Schools of Social Work, Psychology, Psychiatry, Social Welfare State is beginning to target training to consumers to peer groups	There aren't really gaps here; but there is a lack of coordination as to what is offered by whom to whom.	We could not discern a "curriculum" in the many trainings available. There is no consistency across the state as to what works of trainings are available – such consistency would be useful both to providers and consumers.

CONSUMER VOICE	GAPS AND NEEDS	JUSTIFICATION
The consumers are beginning to participate in training through the Children's Mental Health Initiative and some MHD initiatives.	Consumer participation in training – in teaching, learning and designing – is critical. This is particularly true of the partially served and not served consumers.	Consumers and their families must choose services and negotiate the system.

BUDGET	GAPS AND NEEDS	JUSTIFICATION
Existing training budgets are contained in many different places. This is an area where some simplification and coordination might help to leverage some dollars.	CHOICE: New trainings for consumers defining local choices will need to be designed and developed if the system changes. If the system becomes more evidence-based, new trainings or incentives for providers will be needed.	These are not in anyone's budget at present, unless they could replace other trainings.

DATA	GAPS AND NEEDS	JUSTIFICATION
Not Consistently Available: • Outcome data by client, which could facilitate quality improvement by permitting providers and consumers to see "case mix adjusted" outcomes for each provider. • Local information on services available to consumers and families. • Information on which providers are trained in which EBPs – or any fidelity assurances.	NEED: A system of outcomes by client, so that service quality can be assessed and reported by provider, with appropriate case mix adjustments. NEED: local websites showing available service modalities in communities. This website should include information on provider specialties, including EBPs which the provider is trained in delivering. GAP: Providers invest in training themselves; does the state know about that and reward it?	Chapter 2 Consumers and funders need to know which services and providers are delivering effective, evidence-based care. Providers need to know how well their services are working for their consumers.

Mental Health is Consumer and Family Driven

JOBS, SCHOOL AND HOUSING

Overview

Again there is much opportunity for improvement here, and room for leveraging with other programs. There are many employment programs, but it is not clear to what extent consumers with mental illness are using them, or benefiting from them. Housing programs, with their complex mix of local and federal subsidies, are critical.

POLICIES	GAPS AND NEEDS	JUSTIFICATION
JOBS: MHD has minimal expectations and minimal requirements in contract for the RSNs – that 10% of their working age adult consumers earn some wages during a given year. The Medicaid Infrastructure Grant, which focuses on employment for persons with disabilities, has the major policy role in this arena. HOUSING: MHD policy is focused on outreach to homeless clients.	JOB GOAL GAP: MHD Policy is not exactly a stretch goal – more of a "crouch goal." HOUSING POLICY NEEDS: There is room for policies that focus on developing transitional housing, on secure community housing, and on MH services for clustered low-income housing developed by local Housing Authorities. All of these will aid recovery, and some may help keep consumers out of the state and community hospitals.	Recovery is all about working and living in the community. See Chapters 3, 4, 5 (RSN voices), 6. Housing that is a substitute for hospitalization may be justified if it works, and if it is, in the long run, less expensive. Providing mental health services in clustered sites may be more efficient than requiring clients to come in, and may facilitate interaction and peer support in the clustered housing

PRACTICES	GAPS AND NEEDS	JUSTIFICATION
JOBS: Little is being done except to hire consumers. Clubhouses are supposed to help – but do they? HOUSING:Some RSNs are quite active in housing development and state strongly that it has reduced their use of state and community hospitals and reduced the crises for consumers.	JOB GAPS: Need to learn how to help consumers find meaningful work. HOUSING GAPS: Other RSNs want to do this but don't know how. Room for MHD leadership here!	See above

TRAINING	GAPS AND NEEDS	JUSTIFICATION
Isn't much training. More is needed if RSN action is expected. As part of the Medicaid Infrastructure Grant, RDA is working on the development of a website to provide useful local information for jobseekers with disabilities and their families and providers. This is in the planning stages now.	RSNs want to know how to develop housing and help consumers get and keep jobs. Consumers also want to know about work. For them, the website would be useful.	See above

ORGANIZATION	GAPS AND NEEDS	JUSTIFICATION
Right now job development for MH consumers would mostly be carried out by Division of Vocational Rehabilitation or Employment Security Work Source partners. The Medicaid Infrastructure Grant is already coordinating work in this area. That steering committee has a number of projects. Housing and homelessness are mostly managed at local levels. The state agency responsible is Community, Trade and Economic Development. Who should lead?	GAP: If job coaching is needed, who should do it? Should RSN staff be trained? Should the job work be contracted to DVR or Work Source? GAP: If housing needs to be developed, how should the RSNs be involved? Best practices – or just ideas about practices – might be useful. GAP: State leadership on housing issues for mentally consumers. Should DSHS take a more proactive role?	See above

CONSUMER VOICE	GAPS AND NEEDS	JUSTIFICATION
JOBS: Consumers are speaking loud and clear on this topic. Who is supposed to listen to them? HOUSING: Public housing has tenant input and agencies have them also, but not specifically focused on mental health consumers.	JOB GAP: Consumers should be involved in job coaching; peers who have found work are critical allies in this process, as are groups of fellow searchers. HOUSING: Is it important for consumers to be heard separately, or should they join local coalitions of disabled persons seeking to impact local housing decisions? Or both?	Chapters 3, 4, 5 and 6 all suggest that both providers and consumers believe that one important source of job help is from employed consumers and peer counselors.

BUDGET	GAPS AND NEEDS	JUSTIFICATION
JOBS: In FY2004, 6,825 MHD consumers also received services from DVR. That was 23% of DVR's clients. DVR spent almost $9 million on those MHD clients; an average of $1,314 during that year. HOUSING: At present it is impossible to know if DSHS consumers with mental illness are living in subsidized housing, or are homeless, because we have not matched with their data.	GAPS: There are information gaps discussed below, for both housing and employment services.	Useful to know if one is going to focus on effectiveness.

DATA	GAPS AND NEEDS	JUSTIFICATION
We only have some cross-matched data, which makes it impossible to answer the questions under "Gaps and Needs."	Right now we need cross-matched data to answer the following questions: • What employment services are DSHS mental health consumers receiving? (except for the MHD/DVR overlap) • How much do those services cost? • How well are they working? • What services is DSHS providing to consumers with mental illness who are homeless or at risk of homelessness? • How many consumers are homeless, for how long? • How many consumers are housed in subsidized housing?	Hard to know if we are improving situation if we don't know who we are serving or what their employment and housing situation is.

Mental Health is Consumer and Family Driven

CARE IN JAILS/PRISON, AND TRANSITION TO COMMUNITY CARE

Overview

There are three issues here:

- Mental health treatment in jails and prisons
- Diversion from jails and prisons (the "front door")
- Successful re-entry into community treatment after jail and prison

Treatment in Jail or Prison: At this point, neither the Washington State jails nor the Department of Corrections (DOC) have any data based estimates of how many inmates need mental health treatment while they are incarcerated. One would assume that the proportion with a current DSM disorder of thought, mood, anxiety, or impulse control would not be less than the general population aged 18 to 65, which would be about 25 percent. It would most likely be much higher – perhaps two to three times as high. Neither the jails nor DOC are staffed to treat this many people, either with medication or individual or group counseling.

Diversion from Jail or Prison: Mental health courts are called for in federal legislation passed in 2004 (the Mentally Ill Offender Treatment and Crime Reduction Act of 2004). http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=108_cong_bills&docid=f:s1194enr.txt.pdf. Washington State has five mental health courts: in Clark County, King County, Seattle, Skagit County, and Spokane. These courts are designed to create sentencing alternative for mentally ill offenders, and hopefully divert them at the "front door."

Another program which might successfully impact diversion is training for police officers and sheriff's deputies in recognizing and dealing with mentally ill persons involved in committing crimes.

Successful Transition after Jail or Prison: State legislation passed as part of the E2SHB1290 required DSHS to work with jails and prisons to expedite medical benefit processing such that inmates who were eligible regained their medical benefit status upon release. The process was not fully funded, but it was partially funded and is working fairly well. DSHS is presently considering proposing a budget request to move to full funding during the upcoming session.

One group of offenders is still unserved when they leave – those who are not eligible for DSHS medical assistance. Right now it looks as if that is about a third of the offenders referred for processing.

POLICIES	GAPS AND NEEDS	JUSTIFICATION
Jails and prisons are responsible for providing needed health care to inmates, within available funds. They tend not to have much in the way of mental health services; medication and medication monitoring are often missing. E2SHB1290, passed last session, requires DSHS to work with jails and prisons to expedite the process of getting people onto state-funded medical assistance on or just before their release – or as soon afterwards as possible. Once on assistance, they can access whatever mental health care is possible under their health plan.	GAPS: Jails do not have adequate budgets for mental health services. Also, consumers are often in and out too quickly for assessment. What is needed in these "fast jail terms" is transitions in and out. E2SHB1290 policy is taking care of "out" but what if anything is taking care of the services "front door" or services within the jails?	Chapter 3 Chapter 6 (Criminal justice agencies)

PRACTICES	GAPS AND NEEDS	JUSTIFICATION
Per the MHD/RSN contract, RSNs are now required to do an initial assessment on request by the jail, to see if person meets "access to care" standards. If they do, they help develop a service plan. If not, they leave.	GAP: There is at present no designated way for jails to develop a service plan for incarcerated consumers who do not meet access to care standards.	Chapter 6
TRAINING	**GAPS AND NEEDS**	**JUSTIFICATION**
Some municipalities have developed training for police officers and sheriffs to assist them in identifying and handling persons with mental illness to divert them from jail.	GAP: Statewide, consistent training for police, as emergency responders, to recognize mental health problems and move such people to hospitals rather than jails.	Chapter 6
ORGANIZATION	**GAPS AND NEEDS**	**JUSTIFICATION**
Some areas have mental health courts. MHD has developed contract language explicitly stating that RSNs must participate in assessments of incarcerated persons referred for 1290 processing.	GAP AND QUESTION: Organizationally, who should be caring for the mental health needs of prisoners and assisting them in transitions to community services if they are not RSN eligible?	Chapter 6
CONSUMER VOICE	**GAPS AND NEEDS**	**JUSTIFICATION**
Mostly only through the Transformation Grant.	Consumer voice is needed around both services and policy	See Chapter 3
BUDGET	**GAPS AND NEEDS**	**JUSTIFICATION**
Part of the RSN budget was "targeted" for 1290 expansion. Was not new money.	GAP: Local jails say they don't have the budget or skills for this work. Do they need additional funding to provide mental health care to inmates?	Chapter 6
DATA	**GAPS AND NEEDS**	**JUSTIFICATION**
Data is being developed on the transition out within DSHS as part of the evaluation of the expedited medical eligibility process.	KNOWLEDGE GAP: Cross-program data is needed to answer the following questions: • How many prisoners have what sorts of mental health problems? • Over a year, what is the MH treatment need in jail and prison? • How is that need being met within those places? • How many of those persons are connected to mental health services in the community when they finish their term?	Chapter 3 and Chapter 6

Mental Health is Consumer and Family Driven

SERVICE INTEGRATION AND COORDINATION

Overview

The Washington State Department of Social and Health Services (DSHS) was formed out of several separate agencies as a single "umbrella human services agency," to integrate and coordinate care for clients and families with multiple problems.

Integration is, however, easier said than done. The DSHS consists of nine program areas, one of which is the Mental Health Division. Each program area has a different service focus; different billing, payment and client information systems; a separate budget; separate federal relationships; and separate lines of staffing and administration. Organizational "silos", in other words, exist within the umbrella agency, as well as between it and other state and local agencies.

Nonetheless, DSHS has a central administrative structure and central program-serving divisions, including a central research capacity and a central budget shop. In recent years, service integration and coordination across programs have become an agency-wide emphasis, fueled in part by policy, in part by potential cost-savings, and in part by cross-program service use, cost and outcome data from the central research shop.

The DSHS Mental Health Division is involved in several significant service integration projects, described in more detail in Chapter 5. They include projects designed to:

- Improve maternal and infant health and pregnancy and birth outcomes through home visits by nurses during pregnancy and infancy (First Steps, statewide)
- Improve long-term outcomes for chemically dependent mothers and their infants and young children through a comprehensive set of expanded, integrated services delivered through a team (Safe Babies, Safe Moms pilot projects)
- Develop and contract for consistent evidence-based mental health services to children and youth (Children's Mental Health Initiative, statewide)
- Better coordination of mental health services to foster children (Foster Care Health Recovery Improvement, statewide)
- Better coordination of mental health services to juvenile offenders leaving institutions (Juvenile Offender Transition, statewide)
- Expedite the transition to community health and mental health services for consumers exiting institutions and jails (Expedited Medical Review, partial implementation funded statewide)
- Better manage crisis and community care for people with co-occurring disorders (A-Teams at the community level, statewide)
- Coordinate assessments, screening and service delivery, particularly in the early intervention stages, through co-location and common screening and referral patterns (Families and Communities Together, Whatcom County)
- Integrate health, mental health, physical health and long-term care for SSI adults and seniors through a capitated rate to a single health plan provider (Medicaid Integration Partnership pilot in Snohomish County)
- Create a set of secure nursing home facilities with lots of mental health services, for persons with dementia and behavioral and impulse control difficulties who were formerly housed in state psychiatric facilities (statewide)
- Carry out a series of legislative mandates and court cases requiring states to administer programs and services for persons with disabilities in "the most integrate setting appropriate," respecting basic civil rights and involving client and family-centered planning.
- Integrate social, health, school and juvenile justice services for youth (King County Systems Integration Initiative)

Integration methods used in these projects include braided funding, blended funding, shared case management teams, single provider taking over all services, shared assessment, and co-location. Some projects are pilots in a single community; some are agency-wide. Several involve community partnerships; several involve partners in other state agencies. As well, DSHS as a whole is involved in blending local leases to allow for co-located programs in as many community service offices as possible.

Service integration projects managed within other agencies could potentially involve mental health partnerships or expanded mental health services to integrate mental health services and screenings more strongly than is now the case. These include:

- "Readiness to Learn" grants to local communities. These are part of the Washington State Education Reform Act passed in 1993, which authorized grants to local community-based consortia to develop and implement strategies to ensure that children arrive at school ready to learn and will be successful in school. The strategies include conducting comprehensive individualized assessments, developing coordinated service plans, co-locating community services in schools, and collaborating on service planning and delivery.
- The Community, Trade and Economic Development Department, which administers the state's housing programs, is working with DSHS to establish methods to assist local housing authorities in providing human services to residents of subsidized housing, particularly apartment complexes.
- WorkSource and Employment Network projects led by the Employment Services Department, aimed at improving employment services to persons with disabilities.

What has DSHS learned in all these efforts? Organizational silos exist to simplify decision-making and operational control – and they serve that function. Working across silos is more complicated and requires continuing effort. The recent Washington State Joint Legislative Audit and Review Committee audit of DSHS service integration (2006) cites The Rockefeller Institute of Government's conclusions in 2003 as a useful summary of what organizational elements have lead to success in service integration (p.19):

- Local level, community wide efforts focused at improving client outcomes.
- Sustained effort over a long period of time using multiple strategies.
- A local motivated staff with strong, continuous central leadership and sound management.

The JLARC audit concludes: ". . . the bottom line in service coordination is that it is hard work and a continuous evolution." (JLARC, June 26, 2006 p. 22)

Service Integration and Coordination

POLICIES	GAPS AND NEEDS	JUSTIFICATION
DSHS itself as an umbrella organization and mandates integration Expedited Medical Reinstatement for persons leaving jails was legislatively mandated. RSNs are mandated to integrate and coordinate services	There is plenty of policy direction to integrate and coordinate services. Policy alone won't work; the structural difficulties caused by different organizational cultures, hierarchy, priorities, isolated information, timeframes, communication – it takes very creative leadership to design integration that works to overcome all those structural obstacles.	Experience. Also, read the Rockefeller report for a national approach; the Washington State JLARC study for a local one, and any of the evaluations that have been written about integration projects.

PRACTICES	GAPS AND NEEDS	JUSTIFICATION
Many existing integration projects involving mental health services and generally including the Mental Health Division and/or a local RSN as a partner.	GAPS: Projects involving integrated services to: • Homeless persons • Consumers and families • Youth in transition to adulthood • A clearer focus on how to handle co-occurring substance abuse and mental health problems would also be useful. GAPS: Consistent clinical research on how to serve these multi-problem consumers is scanty. NEED: A common, strength-based need identification and case-planning tool which could be used across agencies would facilitate all these integration efforts.	GAPS: Clients in these groups continue to be difficult to serve and costly, as they bounce from system to system, accumulating new problems. (Chapter 2 and Chapter 6) These client groups also have great difficulty accessing services or getting appropriate services even when they negotiate the eligibility barriers (Chapter 3) NEED: This issue has surfaced in almost every service integration project DSHS is involved with, particularly when there are multiple community partners.
TRAINING	**GAPS AND NEEDS**	**JUSTIFICATION**
The most relevant agency trainings here are: "Individualized and Tailored Care (ITC)" training was funded by the Mental Health Division; focused on involving the "whole family" in making a case plan. The DSHS Children's Administration sponsored a similar training known as "Wrap-Around" services to families. The Children's Mental Health Initiative provided training on its selected EBPs both to the community and to providers.	GAP: The deepest training needs for integrated service delivery probably lie in the area of developing a cross-program set of evidence-based practices for persons with co-occurring mental illness and other problems, and then training other people in using them. There are several university and hospital based research groups in Washington State concentrating on these clients – but the state has done little so far to link to those groups or to assist them in the training of providers. This is a function the MHT could assist!	How to manage services to clients with multiple problems is under-researched and potentially extremely important. See the co-occurring disorder chart in Chapter 2.
ORGANIZATION	**GAPS AND NEEDS**	**JUSTIFICATION**
Generally integration projects are managed with cross-program or cross-agency steering and advisory committees and staff working groups.	PROBLEM: It is difficult for other agencies and partners to propose service integration partnerships statewide through the MHD, because each RSN has the autonomy to develop its own service integration priorities and plans. The most successful statewide programs involving mental health have been legislatively mandated and involved changes in MHD/RSN contracts. This is not an easy approach.	See agency comments in Chapter 6. This is a well-known problem in RSH organization and structure. On the other hand, some RSNs have used their autonomy to develop strong local integration partnerships.
CONSUMER VOICE	**GAPS AND NEEDS**	**JUSTIFICATION**
The consumer voice is often missing in integration project development, even though it may be strong in each separate agency.	NEED: Develop consistent ways to involve consumers with the co-occurring disorders as part of the design and development of new integrated programs.	It will improve the programs!
BUDGET	**GAPS AND NEEDS**	**JUSTIFICATION**
If integration projects last, they generally develop a dedicated funding stream either within agency budgets or in legislation. Without that, they often fall by the wayside as new priorities emerge.	NEED: If new integration projects are to be proposed, they will need budgets and funding mechanisms. Is there a consistent way to fund and encourage them, or is it better to fund them one by one?	History.

DATA	GAPS AND NEEDS	JUSTIFICATION
Integrated projects need integrated data. Within DSHS, they generally begin with data from the central Research and Data Analysis Division.	NEEDS: Consistent outcome data so that evaluations of various service combinations can use common metrics. NEED: Consistent service dates and cost metrics for mental health services, no matter who delivers them, so that cost offsets across programs can eventually be evaluated. NEED: It is often useful to include information on consumers who need services, as well as those who receive them. So identifications of need are also important.	The MHT proposed these expansions of the Client Services Data Base as part of its original proposal, and they are all moving forward around DSHS clients and some limited expansions to other agencies such as the Health Care Authority.

Mental Health is Consumer and Family Driven

CONSUMER VOICE AND CHOICE

Overview

Consumer voices and choices are the heart and soul of the Mental Health Transformation in several ways:

- ***Consumer Voice:*** Consumers active players in defining and guiding the ongoing changes.
- ***Peer Services:*** A key measure of the system success of the transformation is the growth and use of peer services as treatment offerings.
- ***Consumer Choice:*** A key measure at the individual level for each consumer – are they empowered to choose important aspects of their treatment?

How these three levels of consumer voice and choice are embodied in policy and practice in Washington State are the issues we must wrestle with now.

Consumer Voice: This can be operationalized within the Mental Health Division and the Mental Health Transformation.

- Are consumers part of committees and work groups which seek to "define" and "flesh out" policy directions?
- Are they there in some numbers, so they are not lone voices?
- Are they heard? (more difficult, but still possible)
- Are they regularly surveyed about their services?

But how can "consumer voice" be operationalized within the other agencies, who offer mental health services as only part of their work? When those agencies seek input from their clients, they are not speaking primarily about mental health consumers, but about all of their clients, only some of whom have mental health problems. Can consumers truly be heard if they are always a minority voice on a client advisory board, or a subgroup in a general satisfaction survey?

Possible answers are included below, more to stimulate discussion than to provide definition.

- Develop a set of consumer and family organizations, who represent mental health consumers no matter where they are served. The problem is, how do they influence policy and practice outside of the MHD?
- Continue, expand, and institutionalize the process of reaching for survey input from consumers who are partially served or not served, or served outside the MHD. Who should do this? And who will carry those voices forward to policy-makers?

Peer Services: A key measure of the system success of the transformation is expansion of the reach and effectiveness of peer treatment organizations.

- How many peer organizations exist; what is their capacity; are they available across the state?
- How many state agencies are authorizing their use, as part of treatment plans, for consumers among their clients (for example, could use of peer services be approved as part of a TANF plan for a mentally ill TANF parent? Or funded by DVR, as part of an employment plan?
- Are people being informed about them? Choosing to use them? When surveyed, are they finding them useful?
- How are the outcomes for the consumers who use them, compared to similar consumers who use other services? In that analysis, what is an adequate "dose" for evaluating their impact on consumers?

Consumer Choice: A key measure at the individual level for each consumer – are they empowered to choose important aspects of their treatment?

On an operational level, however, what does that mean? Does it mean that consumers can:

- Refuse treatment, even if it worsens their illness? (involuntary commitment is one limit to this; are there others?)
- Decide when to engage in treatment?
- Choose from a local list of "approved" providers?
- Choose the "kind" of treatment they want, even if another treatment type has been shown to be more effective?
- Choose life goals and work with a recovery coach or a treatment team to figure out how to operationalize them?

What about family members; how does consumer choice fit them? Some families – parents of children, caretaking relatives for dependent elders – clearly need to be involved in the mental health treatment process at some level. What about the families or guardians of developmentally disabled persons? And what about other family members? Spouses? Guardian siblings?

Consumer Voice and Choice

POLICIES	GAPS AND NEEDS	JUSTIFICATION
VOICE: The Mental Health Transformation mandates consumer participation on its committees and work groups. **VOICE:** MH Planning Advisory Council is 51% consumers and is required by federal and state law. MHD has also added other organizations and staff positions in its Strategic Plan and Block Grant Application. **PEER SERVICES**: MHD is committed to expanding peer services in its strategic plan and its Block Grant for 2006. Other agencies are silent on this policy issue. **CHOICE:** "Encourage consumers, their families and advocates to drive their own mental health care and to be involved in their own recovery and resiliency process supported by the mental health system" (MHD Strategic Plan, page 6)	**VOICE GAP**: Consumers who are not eligible for Mental Health Division services are not included in their MHPAC. Where are their voices? That is a lot of people. **DECISION:** If those voices are heard, who is to engage with them in the policy process? Does MHD have a policy role around the voices of consumers who are not part of its service mandate? If so, how is it engaging them? If not, who does? **CHOICE GAP:** Is there general policy mandating consumer choice in treatment? And consumer and family education about choices?	**VOICE**: It is hard to imagine this process without the consumers as deep participants. How can you change a system without working with the people you are supposed to be helping? Who else knows the system's deepest weaknesses and strengths? **PEER SERVICES:** Peer services are considered effective and helpful by many consumers who have used them. I am not sure how the focus on peer services is justified, since they have not been consistently evaluated. **CHOICE:** It is also hard to imagine a mental health recovery process that did not involve deepening consumer choices as part of the process.

PRACTICES	GAPS AND NEEDS	JUSTIFICATION
MHD VOICE: The Mental Health Division has an Office of Consumer Advocacy responsible for developing consumer participation in MHD policy and planning Two consumer staff are currently employed by MHD: one is the Parent Advocate; the other is the Peer Support coordinator. Statewide parent/youth group – SAFE-WA – speaks for kids and parents. Some RSNs also have parent youth groups – Pierce, Clark, King and Spokane. MHD regularly surveys a random sample of consumers about their services. So do most of the other agencies, but only MHD will be specifically speaking to satisfaction and involvement in their **mental health services.** **The MHT** added, in this resource/needs inventory, the voices of the partially served and unserved consumer around mental health policy and transformation. **AGENCY CHOICE**: Chapter 5 describes the MHD efforts to involve consumers in choices about their treatment and recovery. Chapter 6 describes the efforts of other state agencies. **NOTE:** Child welfare, juvenile rehab, developmental disabilities, and home and community services explicitly involve parents and caregivers in case planning. But this may be more in the role as caregivers than as adjunct consumers.	**VOICE GAP:** Same question as above – what about the non-MHD consumers; how are they involved? Right now they can talk to the MHT and the MHT can con convey their concerns to the appropriate decision-maker. **PEER SERVICES GAP:** Is any group that hires peers a peer service? Are they "licensed" by anyone, or can any consumer start one? What are the rates for their services? Who can use them? **MHD CHOICE NEED**: An operational definition that can be monitored, of what it means for consumers to "drive their own mental health care and be involved in their own recovery and resiliency process. " This is a good policy goal, but what does it mean in practice? How will we know if it is happening? Through surveys? Through expansion of the treatment modalities? Through **OTHER AGENCY CHOICE NEEDS:** And can we extend that definition to the non-MHD mental health consumer?	**VOICE:** This issue needs somehow to move beyond the MHD – or the MHD has to be, in policy and in practice, given the "overall" responsibility and authority to speak on the behalf state consumers that it does not serve. **PEER SERVICES**: To avoid fraud and waste, if peer services are to charge, for them to have some "authorizing" rules. **CHOICE:** This really needs more definition than it has at present, so defining it is the next task. And extending that definition to the other agencies – particularly child welfare and Juvenile Rehabilitation – is essential. How does choice fit with EBPs? Do people simply get to choose from the EBP list?

TRAINING	GAPS AND NEEDS	JUSTIFICATION
CONSUMER TRAINING: Lots of MHD training for consumers and families (Chapter 5, page 87) including some training on recovery Child welfare and juvenile rehabilitation explicitly involve parents or caregivers in some trainings.	CONSUMER CHOICE GAP: Training for consumers across the various programs is inconsistent. CONSUMER VOICE GAP: Training led by consumers is even more inconsistent. PEER SERVICES: There is not clear training for peer service organizations across MH programs.	

ORGANIZATION	GAPS AND NEEDS	JUSTIFICATION
MHD speaks for and involves the most severely mentally ill consumers.	CONSUMER VOICE GAP: Who speaks for the partially served and unserved outside the MHD – or, to whom those consumers should speak.	

CONSUMER VOICE	GAPS AND NEEDS	JUSTIFICATION

BUDGET	GAPS AND NEEDS	JUSTIFICATION
MHD has specific expansion goals for peer services, as does DVR. Other agencies do not.	PEER SERVICE USAGE: The cost of using/contracting with peer services needs to be identified in all agency budgets or reimbursements.	Can't do it if you don't pay for it. And can't measure how much is being done if the expense isn't included in payment systems.

DATA	GAPS AND NEEDS	JUSTIFICATION
CONSUMER VOICE: Usually measured through participation in committees and tasks forces. **PEER SERVICES:** Need to be flagged for all agency databases. **CONSUMER CHOICE:** Is mostly operationalized through answers to survey questions, such as -I have a say in what happens to me when I am in crisis -Staff give me complete information in words I understand before I consent to treatment or medication." -My treatment plan goals are stated in my own words.	**CONSUMER VOICE GAP:** Once we figure out how to operationally measure this outside of MHD, that information needs to be collected across agencies. **PEER SERVICE GAP:** Need to record consumers using consumer-run services – any use and intensity of use. Also need to have a record of peer services and their capability and capacity. **CONSUMER CHOICE GAP**: Once operationalized, data on choice needs to be collected. If it is measured by practices, these need consistent definitions. If it measured by consumer self-report, a survey sample group needs to be defined across all agencies.	Performance measurement for Governor and TWG.

Disparities in Mental Health Services are Eliminated

ACCESS TO CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES

Overview

***Centennial Accord*:** Almost all (26 out of 27) of federally recognized tribal governments whose reservations and tribal lands are surrounded by the State of Washington have signed the Centennial Accord, which says they will work together with state government on common issues. See http://www.goia.wa.gov/Government-to-Government/Data/CentennialAccord.htm

Diversity and Equality in State Government:: Washington State does not use formal affirmative action strategies, following voter passage of Initiative 200 in 1998. However, state government still requires the submission of annual reports from the on government contracting and purchases from minority and women owned business enterprises (RCW 39.19.030(8) and 39.19.060). For the latest report, see the website of the Office of Minority and Women Owned Business Enterprises.

The following State Cultural/Race/Ethnicity Offices and Commissions monitor key issues and state government actions by group.

- Commission on African-American Affairs, http://www.caa.wa.gov/
- Commission on Asian-Pacific Americans Affairs, http://www.capaa.wa.gov/
- Commission on Hispanic Affairs http://www.cha.wa.gov/
- Office of Indian Affairs http://www.goia.wa.gov/
- Office of Minority and Women Owned Business Enterprises: http://www.omwbe.wa.gov/

***Translation and Interpretation*:** DSHS operates a translator certification for State Government; information on that service may be found at http://www1.dshs.wa.gov/msa/ltc/about.html. Again, state agencies need to develop supporting policies and practices. Some agencies prefer to use non-certified translators as they are generally less costly.

Each state agency has its own policies amplifying and supporting these state policies, and often its own stakeholder groups as well. And within DSHS, each program area will have policies and practices supporting those DSHS goals as well. DSHS policies are shown below, as an example of these policies.

DSHS: DSHS Administrative Policy 7.01, amplifying the Centennial Accord, monitored by the Indian Policy and Support Services, advised by the DSHS Indian Policy Advisory Committee (IPAC). Collectively, this policy is designed to assist the collective needs of the Tribal governments and other American Indian organizations to assure quality and comprehensive service delivery to all American Indians and Alaska Natives in Washington State. Each DSHS program to develop a biennial implementation plan for this policy. The Policy 7.01 Implementation Plan and the annual Progress Report shall be developed in consultation and collaboration with the Tribes and Indian Organizations. A uniform matrix format shall be used for the purpose of performance measurements. See Attachment 1: Policy 7.01 Implementation Plan Reporting Guidelines.

The DSHS Equal Employment and Affirmative Action Policy states that DSHS is committed to equal employment and equal access to its programs or services for all persons without regard to race and a number of other characteristics. http://www1.dshs.wa.gov/pdf/ea/dao/policystatement.pdf. This policy is monitored by the DSHS Diversity Affairs Office. In its most recent Strategic Plan, DSHS identifies three diversity foci: employment, client services and outcomes, and cultural competency in service delivery. Each DSHS program then includes diversity plans, activities and measures.

DSHS Limited English Proficiency Administrative Policy 7.21 requires translations and interpreters if a head of household needs them. Again, each DSHS program develops its own forms, translates them into the basic languages needed, and makes translators available when needed.

Disproportionality in Mental Health Service Outcomes: However, cultural competence in mental health service delivery involves much more than translation and interpretation or affirmative action. Cultures vary profoundly in the way they define mental health and illness, help-seeking behavior, and the nature of help. For this reason, the mental health transformation will progress furthest by examining equality or disproportionality in the key outcomes of mental health services, rather than beginning with equality or disproportionality in service delivery.

Perceived Conflict Between EBPs and Cultural Competence: An analysis of outcomes by race/ethnicity would lead towards some resolution of the perceived conflicts between evidence based practice and culturally based practice, by focusing discussion on the outcomes for clients.

POLICIES	GAPS AND NEEDS	JUSTIFICATION
STATE: Centennial Agreement with the tribes. Translations and Interpretation required for households if needed.	GAP: There does not seem to be an overall state policy on cultural competence in service delivery.	
PRACTICES	**GAPS AND NEEDS**	**JUSTIFICATION**
Governor Offices for each of the major minority groups Office of Minority and Women Owned Business Enterprises monitors contracts and expenditures. DSHS licenses interpreters and translators. DSHS required forms are translated into six languages.	GAP: Analysis of areas where mental health practice is not culturally competent, by examining mental health outcomes by race/ethnicity.	
TRAINING	**GAPS AND NEEDS**	**JUSTIFICATION**
Much training for staff and providers; this is all very decentralized in practice.	GAP: Exceedingly difficult to see what is actually happening on the ground, with all this variation in what is supposed to happen.	See general discussion above this section of the table.

ORGANIZATION	GAPS AND NEEDS	JUSTIFICATION
Each program and often each region has their own plan.	Impossible to monitor at state level. This may need some elevation if MHT is going to focus on it.	
CONSUMER VOICE	**GAPS AND NEEDS**	**JUSTIFICATION**
In Chapter 3, 12 out of 126 underserved consumers interviewed said that the services they were offered were culturally in appropriate – that is about 10%.	GAP: Need more analysis on these issues.	See Chapters 3.
BUDGET	**GAPS AND NEEDS**	**JUSTIFICATION**
The relevant question here is not what is being spent on staff and provider training and reporting. Instead, it would be how much are we spending on mental health services, relative to need, within each minority group.	GAP: Information on which consumers are served, across agencies. Once that information is available, it will be possible to report service parity by ethnicity.	Provides the "right" information. This could also be used to answer questions about impacts of EBPs on minority populations.
DATA	**GAPS AND NEEDS**	**JUSTIFICATION**
The impacts of mental health services on consumers cannot be analyzed. No common cross-agency data, no outcomes.	GAP: Information on outcomes for consumers, across agencies.	Provides the right information.

Early Mental Health Screening, Assessment and Referral are Common Practices

EARLY INTERVENTION AND SCREENING

Overview

Only a handful of agencies and programs in Washington State offering mental health-related services are in the "business" of early intervention and screening. The majority of agencies and programs (including the Mental Health Division), and the majority of mental health dollars, are used to serve individuals who have "deep end" mental health disorders. Despite this reality, spokesmen from every agency interviewed for this report spoke of the clear need for stronger efforts in the area of prevention and early intervention.

Agencies and Programs Focused on Early Intervention

Existing Services

- The Department of Health (DOH) funds some early intervention-related services and training in each of the state's 35 local health jurisdictions. It also funds statewide public information campaigns about mental-health related issues such as suicide and post-partum depression.
- The Family Policy Council (FPC) promotes reforms to improve mental health outcomes for children, youth, and families. It also oversees 36 Community Public Health and Safety Networks; the Networks are legislatively mandated to focus on prevention of child abuse and neglect, youth violence, youth substance abuse, teen pregnancy, domestic violence, school dropout, and teen suicide.
- A variety of other programs throughout the state – serving varied populations such as disadvantaged youth, disabled workers, and crime victims – routinely screen for developing mental health disorders and endeavor to make appropriate and timely referrals. Unfortunately, none of these programs have a large mental health budget or an exclusive focus on early intervention and screening.

Recommended Services

The agencies and programs focused on early intervention named a variety of services their clients need, but have difficulty accessing, including the following:

- Children's therapy in general, and attachment therapy in particular
- Public education about the predictors of child and teen suicide
- Mental health services for the parents of abused children
- Co-occurring treatment for adolescents (including specialized treatment for developmentally disabled adolescents)
- Timely and appropriate trauma-related therapy for crime victims (both children and adults)

Agencies and Programs Not Focused on Early Intervention

Existing Services

- The Juvenile Rehabilitation Administration (JRA) offers family-focused Functional Family Parole to all youth on community supervision, and evidence-based Functional Family Therapy to selected "at-risk" youth, in an effort to create mentally healthy environments for parolees and their families.
- The Department of Veterans Affairs (DVA) provides one-on-one and group therapy to war-era veterans; an effort is made to offer such services "early on," so that mental health disorders can be prevented or more effectively managed.
- The Children's Administration (CA) offers treatment foster care, family reconciliation services, and counseling for children who are "aging out" of the foster care system, all in an effort to prevent or best manage mental health disorders in children and youth.
- The Division of Alcohol and Substance Abuse (DASA) provides some prevention-related services, including school mentoring programs; parent education programs; and advocacy for change in state and local laws, ordinances, and policies.

Recommended Services

The majority of agencies and programs in Washington State that provide or support mental health services are not focused on early intervention and screening. Nonetheless, they noted the need for such activities, and specifically suggested the following:

- More money and resources should be spent to encourage Washington residents to seek help early for psychological issues that can lead to impairment or death
- Clients with mental health disorders should receive counseling as early as possible in their substance abuse cycle, as substance abuse exacerbates mental health issues
- More attention needs to be paid to early intervention for individuals with both developmental disabilities and mental health disorders.
- "The whole state" needs to be aware of and support the Children's Anti-Violence Campaign
- Youthful offenders need to be offered appropriate mental health services, rather than be punished and stigmatized.
- Individuals with mental illness, veterans, and adult offenders all need long-term supported employment (employment and mental health medication/treatment) in order to maintain optimum mental health.

Early Intervention and Screening

POLICIES	GAPS AND NEEDS	JUSTIFICATION
Per policy, MHD does not fund early intervention or screening Per policy, DOH supports some early intervention programs in each of 35 Washington State local health jurisdictions. Per RCW 70.190, FPC promotes reforms to improve mental health outcomes for children, youth and families; it works with 36 Community Networks established by the 1994 Youth Violence Reduction Act. A variety of smaller agencies and programs are mandated to serve and advocate for adults and children at risk for mental health disorders.	GAPS: Funds need to be spent on "up front" activities such as educational campaigns and early assessment and referral. GAP: Internal policies must be changed to encourage staff to accurately assess and appropriately refer clients to mental health services, and to allow staff to collaborate with staff from other agencies. ALL GROUPS: Stronger efforts must be made in the area of early intervention and prevention.	Current early intervention and screening policies: Give families of children and youth with mental health little or no help, other than medication from state health care (Chapter 1) Create a disincentive for schools and other agencies serving youth to screen for mental health problems (Chapter 1) Leave many individuals with mental health disorders undiagnosed until their issues become chronic or severe (Chapter 5, Chapter 6) Provide many individuals with mental health disorders with medication but no treatment, increasing the likelihood of acute or chronic mental illness (Chapter 6) Leave a variety of populations – including youth, the elderly, troubled families, veterans, and the developmentally disabled – without needed mental health treatment (Chapter 6)

PRACTICES	GAPS AND NEEDS	JUSTIFICATION
The majority of agencies and programs who serve individuals with mental health disorders focus on treatment of existing (and often acute) disorders, rather than on prevention and early intervention.	GAP: Housing and employment must go "hand in hand" with counseling, and too often they do not; it is wrong to wait until a person is debilitated before offering support. GAP: Increased staff training regarding "indicators" of mental health disorders; increased use of evidence-based assessment tools; more effective collaboration between agencies/programs serving clients with mental health disorders; treatment of "whole families," not just individuals.	Current early intervention and screening practices: Are rendered moot if there is no access to needed services, because such services do not exist or are not affordable (Chapter 1) Simply fail to "reach" many who are in need of mental health services (Chapter 5, Chapter 6) Are not appropriate for certain populations, including those who cannot speak, those who do not speak English, and those who are developmentally disabled (Chapter 6)

TRAINING	GAPS AND NEEDS	JUSTIFICATION
The few agencies and programs that focus on early intervention and prevention activities tend to lack funding to do regular staff training.	GAP: Lack of funding for ongoing training on evidence-based practices (related to early interventions). GAP: Increased staff training regarding "indicators" of mental health disorders, so more effective assessments can be completed and more appropriate referrals can be made; increased staff education about mental health resources in the community.	Current early intervention and screening practices: The Department of Health funds early intervention–related training and conferences in local health jurisdictions; mounts statewide public education campaigns regarding mental health disorders (Chapter 6). Most other programs focused on early intervention hire staff with proper credentials, but lack the funds necessary for ongoing training (Chapter 6).

ORGANIZATION	GAPS AND NEEDS	JUSTIFICATION
Early intervention and prevention efforts tend to occur 1) in small, relatively poorly funded, organizations or 2) as an adjunct to the real "mission" of larger organizations. Agencies and programs with similar early intervention goals often fail to collaborate.	NEED: A stronger effort to communicate with and educate those who directly impact our clients' lives, including employers, landlords, teachers, and medical personnel. NEED: A higher priority for early intervention efforts in our agencies/programs, and more communication with other agencies/programs involved in similar efforts.	Current early intervention and screening organization: Creates "silos" of activity, when coordinated efforts across agencies serving similar (and often, the same) clients would be more productive and cost effective (Chapter 1) Makes early intervention and screening efforts a "poor cousin" of services to those who are acutely mentally ill (Chapter 5, Chapter 6).

CONSUMER VOICE	GAPS AND NEEDS	JUSTIFICATION
Potential consumers have no voice concerning the lack of early interventions; many are unaware that they are in need of mental health services. Actual consumers of early interventions often must "take what they can get".	NEED: Early intervention agencies state that the motivation for their efforts is their desire to give their clients a strong "voice" in the community; admit that they (the agencies/programs, and the clients) sometimes feel unheard. NEED: Non-early intervention agencies point out that they lack the resources to respond to the "voice" of their clients with diagnosed mental health needs; they are aware there are many others "out there" who need services as well, but are not in a position to serve, or even refer, them.	Consumer voice in current early intervention and screening efforts: Is virtually non-existent (Chapter 4, Chapter 6).

BUDGET	GAPS AND NEEDS	JUSTIFICATION
The majority of mental health dollars are spent on services for individuals who are acutely or chronically mentally ill, rather than for those on the "front end" of mental health problems.	DISAGREEMENT: Agencies focused on prevention and early intervention feel strongly that more federal, state, and local dollars dedicated to early intervention are needed to support individuals in recovery and educate the populace. However, other agencies suggest strongly that it is difficult to justify allotting more monies for early intervention when current clients lack basic services.	Early intervention and screening dollars: Are very limited (Chapter 1; Chapter 6).

DATA	GAPS AND NEEDS	JUSTIFICATION
Several agencies track the outcomes of individuals involved in prevention/early intervention activities. However, the data is not always collected consistently, and is rarely shared across systems. There is no method of estimating the "unserved."	Gap Identified by Agencies/Programs Focused on Early Intervention: More data needs to be shared between agencies for programming and research purposes. In order to do so, confidential releases must be standardized and data sharing agreements must be reached. This is difficult within DSHS, and even harder among agencies outside DSHS. Even agencies not focused on early intervention concur.	Early intervention and screening data: Each agency/program keeps data regarding its own early intervention clients and programs. Very little data is shared, even between DSHS agencies (Chapter 2, Chapter 6).

Early Mental Health Screening, Assessment and Referral are Common Practices

SCHOOL AND PRIMARY CARE COLLABORATION

Overview

A minority of public schools, pre-school programs, and primary care (health care) agencies and programs in Washington State work together with mental health care providers to assure that individuals are screened for mental health disorders and referred to appropriate mental health services in a timely manner. Many more schools and health care agencies see the need for and value in early screening and referral, but lack the mandate and the resources to provide such services.

Existing School/Mental Health Collaborations

- The Office of the Superintendent of Public Instruction (OSPI) funds the "Readiness to Learn" program. This program, operating in 350 of 2200 schools statewide, focuses on working with students who struggle with depression and lack of academic motivation. It fosters collaborations between schools and community-based mental health providers.
- OSPI and the Division of Alcohol and Substance Abuse (DASA) partner to sponsor the Prevention and Intervention Services program in 800 schools statewide. Program components include the placement of "Intervention Specialists" in schools, the "Safe and Drug Free Schools" curriculum, suicide prevention, violence prevention, substance abuse treatment, and case management for students with mental health disorders. (Different components are available in different schools).
- The Early Childhood Education Assistance Program (ECEAP) completes mental health screenings on all children participating in ECEAP pre-school programs, and refers children to community mental health providers when indicated.
- The Governor's Committee on Disability Issues assists youth with mental health disorders to find and maintain gainful employment. The Committee works with special education programs in schools throughout the state to develop work plans for individual youths.
- The Washington Council for the Prevention of Child Abuse and Neglect (WCPCAN) funds the Healthy Start preschool in King County, and the Ages and Stages screening tool, which is used in school districts statewide.

Recommended School/Mental Health Collaborations: The agencies and programs interviewed for this report made the following recommendations concerning school-mental health collaborations:

- More mental health professionals on site in public schools
- More ongoing communication between school staff and community-based mental health treatment providers serving students
- A program in the schools to reach children of military families suffering from the absence or psychological distress of parents
- Special attention for at-risk "foster kids" in public schools
- More money to hire highly skilled staff in specialized preschools

Existing Primary Care/Mental Health Collaborations

- The Office of Crime Victims' Advocacy (OCVA) provides crime victims with access to both medical evaluations and mental health counseling. Medical personnel doing the initial evaluation routinely screen for mental health concerns.

- The Department of Health (DOH) and the Washington Council for Prevention of Child Abuse and Neglect (WCPCAN) will soon implement a statewide educational campaign concerning post-partum depression.
- In some of the state's public schools, school nurses have developed collaborations with local mental health treatment providers.
- In some communities, nursing home staff members have developed collaborations with local mental health treatment providers.
- In Economic Services Administration Community Service Offices (CSOs), staff work with clients to create Individual Responsibility Plans (IRPs) which include agreement to ongoing collaboration between the individual's medical and mental health care providers.
- The Division of Alcohol and Substance Abuse's (DASA's) pregnant and parenting women's services involve ongoing consultation between medical and mental health providers concerning the welfare of individual program participants.

Recommended Primary Care/Mental Health Collaboration: The agencies and programs interviewed for this report made the following suggestions concerning primary care-mental health collaborations:

- More partnerships between medical care and mental health care providers in communities across the state, both at a policy level and in the service of individuals with both medical problems and mental health disorders.
- More public information campaigns concerning the interconnection between medical and mental health problems, both for children and adults.
- Increase public awareness that children who have been abused are at greater risk for medical, as well as mental health, problems.
- Encourage medical staff, both in private practice and at public hospitals, to do more routine mental health screenings and referrals.

School and Primary Care Collaboration

POLICIES	GAPS AND NEEDS	JUSTIFICATION
Per policy, OSPI funds and provides technical assistance to 296 independent school districts statewide. In a minority of those districts, early intervention are operated (some funded by OSPI, and some by DASA). Per policy, CTED funds mental health screenings for all children participating in the ECEAP program. Other collaborations noted above operate under informal agency/program policies.	School/Mental Health Care Collaborations: More funding is needed to support more consistent early intervention programs in school districts statewide. Primary Care/Mental Health Care Collaborations: Policies need to be restructured to allow more data sharing between medical and mental health communities.	Current school and primary care collaboration policies: Leave students in some districts with access to a higher level of service than students in other districts (Chapter 6) Leave medical personnel "in the dark" concerning patients' mental health histories, and vice versa (Chapter 6) Are misunderstood by the general public (Chapter 6).

PRACTICES	GAPS AND NEEDS	JUSTIFICATION
The majority of schools and preschools in Washington State do not have consistent and effective collaborations with community-based mental health agencies/programs. In most communities, medical and mental health professionals do not collaborate consistently or effectively.	School/Mental Health Care Collaborations: School staff and mental health treatment providers need to forge stronger and more consistent collaborations, both inside and outside school walls. Certain student populations need specialized attention. Primary Care/Mental Health Care Collaborations: Medical care providers and mental health care providers need to work more closely together in communities throughout the state, and the state's residents need more awareness of the connection between medical and mental health problems.	Current school and primary care collaboration policies: Often do not provide teachers and families adequate information to make informed decisions for students (Chapter 6) Also fail to give medical and mental health professionals a clear picture of the issues their clients are facing (Chapter 6).

TRAINING	GAPS AND NEEDS	JUSTIFICATION
DOH , OSPI, and FPC all sponsor trainings related to early intervention "best practices" that are accessible to school, medical, and mental health personnel.	School/Mental Health Care Collaborations: School personnel need more "training time"; too often they are overwhelmed by their academic responsibilities. Primary Care/Mental Health Care Collaborations: The situation outlined above also applies to medical and mental health staff, particularly those affiliated with public hospitals.	Current school and primary care collaboration training: Children with abuse and neglect issues or more likely than others to have both medical problems and mental health disorders (Chapter 6)

ORGANIZATION	GAPS AND NEEDS	JUSTIFICATION
While schools and primary care systems share many clients with mental health professionals in their community, they have historically failed to collaborate effectively with those professionals, leading to information "gaps" that hurt clients.	School/Mental Health Collaborations: More on-site mental health professionals in schools; specialized services for children of veterans, foster children, and adolescents with co-occurring disorders. Primary Care/Mental Health Collaborations: More working partnerships between medical and mental health medical professionals in communities	Current school and primary care collaboration organization: "We (ECEAP) see attachment disorders, conduct disorders, and depression in kids all the time" (Chapter 6) Schools and community mental health providers need to work more closely to support children with mental health disorders (Chapter 6) "There is a silo effect even in our (the RSN) community; there is no flexibility in funding to meet needs of joint clients" (Chapter 5)

CONSUMER VOICE	GAPS AND NEEDS	JUSTIFICATION
Consumers have little voice, as the number and scope of collaborations is limited. .	School/Mental Health Care Collaborations: Students and their families need a stronger voice in the types of interventions available in school settings. Primary Care/Mental Health Care Collaborations: Consumers of medical/mental health services deserve a voice in the process; confidentiality is an ongoing issue.	Consumer voice in current school and primary care collaboration efforts: It is virtually non-existent. (Chapter 4, Chapter 6).

BUDGET	GAPS AND NEEDS	JUSTIFICATION
As with other early intervention activities, the funding for school/mental health and primary care/mental health collaborations is very limited.	School/Mental Health Collaborations: More funding is needed to support school/mental health collaborations (to create more consistent access in schools statewide) Primary Care/Mental Health Care Collaborations: More funding is needed to support primary care/mental health collaborations (salaries, data sharing, etc.)	School and primary care collaboration dollars: Are very limited (Chapter 6)
DATA	**GAPS AND NEEDS**	**JUSTIFICATION**
While some agencies/programs keep outcome data, it is not collected in a consistent manner and is infrequently shared across systems.	School/Mental Health Collaborations: More data sharing agreements. Primary Care/Mental Health Care Collaborations: More data sharing agreements.	School and primary care collaboration data: Each agency/program keeps data concerning its own early intervention clients/programs. Very little data is shared. (Chapter 6)

Excellent Mental Health Care is Delivered and Research is Accelerated

SERVICE QUALITY

Overview

Policy is moving rapidly in this area!

In January 2006, Governor Gregoire issued an executive order on Chronic Care Improvements directing the DSHS, the Department of Health, and the Health Care Authority to collaborate improving chronic care. The three agencies were directed to "survey current interventions and comparing them to 'best of class' ". Also, they were directed to "identify and encourage treatment that works – an evidence-based approach to chronic care." http://www.governor.wa.gov/actions/orders/dir_06_02.pdf.

In response to this directive, the Health and Recovery Services administration has just issued an RFP called the Washington Chronic Care Management Project. This project calls for a case management contract that "provides patient focused service delivery using evidence-based medicine." Many of the potential consumers will have mental illness as well as other chronic conditions, and the RFP says:

> "bidders will be expected to develop a community-based program, including referral and linkage to medical, mental health and chemical dependency service providers and other social services."

The RFP may be found at http://www1.dshs.wa.gov/msa/ccs/procurement/HRSA-OCC-0106.htm.

Mental health providers in Washington State have been working for years to "train up" to the programs state policy-makers want to fund – as well as those programs their own review of the literature suggests are most effective. Their training budgets, however, are limited, so there are lags in their ability . The table below shows how many providers are trained in practices which some part of the mental health systems is now mandating.

NOTE: Agression Replacement Therapy is available in the community, but these mental health providers did not mention it.

Evidence-Based Practice	MHD	Providers	JRA	CMHI
Aggression Replacement Therapy-ART			✓	
Assertive Community Treatment-ACT	✓	✓ 17		
Dialectical Behavior Therapy-DBT	✓	✓ 18	✓	
Elderly Depression Screening & Treatment		✓		
Family Psychoeducation	✓	✓ 15		
Functional Family Therapy-FFT		✓ 10	✓	✓
Family Integrative Therapy-FIT			✓	✓
Illness Self-Management and Recovery	✓	✓ 12		
Integrated Co-Occurring Disorders		✓ 19		
Medication Management		✓ 25		
Multidimensional Treatment Foster Care		✓ 7	✓	✓
Multi-Systemic Treatment-MST		✓ 18	✓	✓
Parent Training		✓ 26		
Trauma-Focused Cognitive Behavior Therapy				✓
Wraparound		✓ 26		

Meanwhile, providers, some consumers, researchers, and policymakers in the mental health and social service community in Washington State have been involved for some time in a passionate discussion about evidence-based practices. This debate is not theoretical; it has emerged as the DSHS Juvenile Rehabilitation Administration, Mental Health Division and Children's Administration move to require/facilitate the adoption of the following Evidence-Based Practices. The discussion revolves around a number of issues which in many ways echo similar discussions within the research community.

- **Impacts:** What is the nature of the evidence? What is changing for the consumers studied? Does the treatment make any difference in the consumer's everyday life? Does it change the nature of future services they need or use?
- **Comparison Groups and Treatments:** Who is in the comparison groups, and what sort of treatment did they receive? How similar are the comparison group treatments to "treatment as customary" in Washington State? Do evidence-based treatments work for all groups in similar ways? Washington State has some ethnic and cultural groups not found in other parts of the country – American Indians and many groups of Asians. These groups are usually not part of the treatment and comparison groups in other places.
- **Dose Effects:** How is dose effect controlled in the research design (in other words, is it the amount of treatment rather than the kind that led to a treatment/comparison difference).
- **Fidelity, Training and Quality Assurance:** How important is fidelity to every detail of the treatment? Can one adapt the treatment and still consider it "evidence-based?" How is the community to support the training needed if policy decisions move intensely towards evidence-based treatments?
- **Who Gets These Treatments?** What works for whom? How does evidence-based treatment fit with consumer choice? How well do treatments work with multi-problem clients; how much evidence do we have about that group?
- **What about Consumer Choice?** Consumers, families and providers have been trained over the past ten years to work within clinical frameworks of "individualized and tailored care" and "wrap-around services." These programs emphasize working the whole family and designing treatments around consumer goals. How do evidence-based treatments fit within that model of care?

- **Fragmentation and Evidence-Based Practice:** How as a state do we make policy decisions about supporting evidence-based mental health treatment, given the fragmentation and access problems of mental health service delivery?
- **How to Support Continuing Evolution and Improvement in Practice:** Given the state of the research in health and mental health care – many practices being studied, not yet clear decisions as to what paths are best – it is critical to find a way to support treatment in a continually changing environment.

For the Mental Health Transformation, the most intense discussions on this topic did not occur during our interviews on current practices, except in the focus groups with providers. Instead they took place in four task groups:

- Evidence-Based Practice, which in the process of its discussion transformed its name to Evidence-Based, Promising and Emerging Practices.
- Fiscal Task Group, around the issues of effectiveness and stretching scarce resources and continuing practice evolution.
- MIS group, around data needs to support research on best practices and subgroups.
- Cultural competency task group, around who is part of the evidence.

The conclusions across all groups were:

- Washington State needs to develop incentives to support health and mental health providers to adopt treatments and practices that improve consumer outcomes and support consumer recovery.
- These incentives need to be integrated across the health and social service care spectrum, not isolated in one organizational silo or another.
- Local studies with our populations, using local comparison groups, are as important as national research in demonstrating the effectiveness of those practices and treatments.
- State monitoring should focus on real life "outcome" improvement rather than fidelity to care standards (although since treatment fidelity may be necessary to improve outcomes, it will still remain a focus of training at the provider level).
- Administrative outcomes collected for each client facilitate provider incentives to adopt good evidence-based practices by facilitating "case-mix adjusted" comparisons of the outcomes achieved by the clients treated by each provider group.

Service Quality

POLICIES	GAPS AND NEEDS	JUSTIFICATION
Governor Gregoire's 2006 executive order on Chronic Care Improvements The DSHS Mental Health Division, in their 2006 Block Grant, supported a set of EBPS and trainings as well as participating in the Children's Mental Health Initiative. The DSHS Juvenile Rehabilitation Administration is committed to delivering services across their system that really works to reduce recidivism.	NEEDS: Perhaps the most pressing policy need is a focus on the integration of "evidence-based, proven and emerging practices" across silos.	Right now Washington State is managing evidence-practice within organizational silos. That doesn't make a lot of sense – training is expensive and so is fidelity assessment.

PRACTICES	GAPS AND NEEDS	JUSTIFICATION
Evidence-Based Programs are being adopted as quickly as training budgets as possible, despite all the questions discussed above and in Chapter 5. This is true both at state and local levels, despite concerns that most programs have not been tested on Asians or American Indians. There is also a strong and spirited desire to develop some evidence around the effectiveness of locally developed innovative programs.	Even though a lot is going on, there are still many gaps and holes in the evidence-based practice continuum. What is needed? GAP: State needs to encourage clinical research on multi-problem consumers, with good comparison groups. These people are the focus of the Governor's initiative; they are the most expensive and difficult clients, and few EBP's explicitly acknowledge that or focus on those clients. NEED: Ways to spread knowledge of what works. The Internet is key here. NEED: Program Cost-Effectiveness Updates. Washington State Institute for Public Policy has created the best literature review comparing various programs using existing outcome analyses and converting to dollars.	Chapter 2 chart on co-morbidity. The Governor's directive focuses on high-cost, co-morbid consumers. Much of the EBP research involves the other end of the continuum and does not explicitly address the impact of co-morbidity on outcomes.
TRAINING	**GAPS AND NEEDS**	**JUSTIFICATION**
Not consistent across programs.	NEED: Incentives for providers to train in and adopt new practices. NEED: Ways to spread knowledge about new approaches that work. NEED: Consumers and families need to know about these new approaches	Chapter 5. Evidence Based, Promising and Emergent Programs Subgoup report and outcomes
ORGANIZATION	**GAPS AND NEEDS**	**JUSTIFICATION**
Information on EBPs provided or recommended is not readily available. For individual organizations, information is buried on their webpages not linked to public information about choices and rationale. And sets of EBPs favored by more than one agency are not so defined.	NEED: EBP Handbook on the web. Choices, trainers, organizations preferring them, certification information. Both consumer and provider levels of info. NEED: EBPS should be defined and "lit searched" once for all of state government, for all outcomes they have been shown to affect. NEED: Re-orient training resources and contracting practices from within to across silos where practice needs are shared (as in CMHI). GAP: How to reward and incentivise providers and RSNS?	Chapter 6 services – and chapter 2
CONSUMER VOICE	**GAPS AND NEEDS**	**JUSTIFICATION**
Consumers are hard-pressed to find out enough about EBPs to be able to freely choose one.	NEED: Consumers need to know where to find these practices. NEED: Consumer voice must be part of evaluations of emerging EBPs.	If we are promoting them, it would be good to help people find them. If local evaluations are held, consumer satisfaction is important.
BUDGET	**GAPS AND NEEDS**	**JUSTIFICATION**
EBP budgets are not provided; they must be "eked" out of existing funding. This makes them hard to start and hard to invest in, both for providers and agencies.	NEED: Some fiscal support? NEED: Shared contracting arrangements across CA, MHD, JRA, MAA, other agencies? HCA? DVA?	Chapter 6 and Chapter 5

DATA	GAPS AND NEEDS	JUSTIFICATION
EBP evaluations from other places are adopted wholesale, without much discussion of local practices and populations which are, essentially, the comparison group. Consumers are afraid that EBPs will be "pushed" on them. Providers don't necessarily believe new practices are better.	NEED: Outcome Data for consistent evaluations. NEED: Identification of mental health need from multiple sources, to aid in constructing local comparison groups. NEED: Development of research partnerships between state agency researchers and University/medical researchers NEED: Which providers, where, have been trained in which EPBs – for I&R.	Places focus on outcomes rather than "fidelity" – because outcome information is much more convincing than fidelity measures. However, fidelity measures give more clues about what has gone wrong.

Technology is Used to Access Mental Health Care and Information

INTEGRATED HEALTH RECORDS

Overview

Integrated health records hold the enticing promise of overcoming one of the central problems for "team" management of clients with multiple problems – the problem of having no computerized "chart" for the consumer, to record diagnoses, plans and actions taken.

This past session, the Washington State Legislature passed a bill now signed into law (SHB 2573) called "Adopting Health Information Technology to Improve Quality of Care." This law directs the State Health Care Authority to *"promote and increase the adoption of health information technology systems, including electronic medical records"* and to *"coordinate a strategy for the adoption of health information technology systems"* (Section 2-B).

The final strategy is due December 2006 and the stated intent of the bill is to encourage all hospitals, integrated delivery systems and providers to adopt health technologies by 2012. The Department of Corrections is to take the lead in creating a pilot project to test this technology from local jail through prisons and out. (See the bill summary here: http://www.leg.wa.gov/pub/billinfo/2005-06/Pdf/Bill%20Reports/House%20Final/2573-S.FBR.pdf)

The DSHS Health and Recovery Services Administration (which includes the Mental Health Division) was not directed to participate by the Legislature – but is participating anyway as part of the Health Priorities of Government team. Hopefully this strategy will lead to a system which RSNs and mental health providers could embrace along with the general medical sector. And certainly this legislation will really move this train along faster than the Mental Health Transformation ever could move it.

Note: The Mental Health Transformation Information Technology WorkGroup recommended a system somewhat like this to the TWG (called the "Global Consumer Information Center") in early May. The TWG said, essentially, "Wait for the Governor's project on integrated medical records."

INTEGRATED HEALTH RECORDS

POLICIES	GAPS AND NEEDS	JUSTIFICATION
The 2006 State Legislature passed SHB 2573, called "Adopting Health Information Technology to Improve Quality of Care." Law directs HCA to lead this effort, requests a final strategy paper by December 2006 which leads towards adoption of improved technologies by everyone by 2012.	Law does not require DSHS to participate – but the agency is participating anyway. It also isn't clear whether the Legislature would regard mental health information and providers as a first priority for inclusion in such a system.	Improvement of patient care from sharing records; reduction of error; better care coordination for multi-problem consumers.

PRACTICES	GAPS AND NEEDS	JUSTIFICATION
Right now the DSHS Health and Recovery Services Administration is focused on fleshing out the strategies to implement the SHB 2573 policy statement.	Don't know yet.	No strategy yet.

TRAINING	GAPS AND NEEDS	JUSTIFICATION
Not yet relevant.	Don't know yet.	No strategy yet.

ORGANIZATION	GAPS AND NEEDS	JUSTIFICATION
The Health Care Authority is the appropriate agency for this task.	None.	

CONSUMER VOICE	GAPS AND NEEDS	JUSTIFICATION
There is no discussion in the legislation about privacy, confidentiality, or client or consumer voice in the design.	Certainly if the MHT had initiated a project such as this, consumers would have been part of the design team and the development of privacy/confidentiality rules around this technology. That may not happen in this process.	History and experience.

BUDGET	GAPS AND NEEDS	JUSTIFICATION
No fiscal impact for the planning, apparently – and the bill allows the Authority to accept gifts to fund it. Sounds like they have a donor.	GAPS: Money. The development of user requirements for such a system will be costly in both money and workforce time.	Once this bill is past the strategy stage, it will begin to cost money – big money. Success will depend partly on ability to manage scope creep, and partly on defining steps that immediately improve care.

DATA	GAPS AND NEEDS	JUSTIFICATION
A data warehouse developed from a cross-agency, automated medical record would simplify the development of integrated databases recording mental health status and health care encounters (as well as facilitating better patient care one patient at a time).	STILL NEED A CROSS-AGENCY DATABASE: During the life of the MHT, it will still be necessary to match client records across the various information systems in which they reside to develop unified information for monitoring and evaluation. STILL NEED OUTCOMES: Even when this system is in place, it will still be necessary to match client information to other data systems measuring employment, school success or failure, graduation or dropping out, marriages, divorces, births, deaths and other health and recovery outcomes.	System will not be in place until 2012 at the earliest. It will not contain historical data, so that needs to be assembled from the existing systems. And – this might not happen. Meanwhile, this project still needs data.

Technology is Used to Access Mental Health Care and Information

HEALTH INFORMATION WEBSITE

Overview

A mental health information website was not something that our interviews explicitly asked about. Like outcome data, however, the idea kept surfacing as a subtext in people's comments.

- Consumers were asking for local information on services; the easiest way to present that sort of information is on the web, where it can be updated quickly.

How Many Consumers Use the Internet? Many people are used to getting information via the Internet. This is not only true for agency staff and providers, it is true for many consumers as well. About one in six (22 out of 126) underserved consumers interviewed in depth commented that the Internet was useful to them in obtaining information.

On the other hand, a number of clients cannot use computers. 14 out of 126 under-served consumers commented about not being able to use technology to learn about mental health services, mostly because they didn't have a computer available or didn't know how to use one, or had difficulty reading and writing.

Internet Information Enhances Consumer and Family Choice by Spreading Knowledge Deeper Into the Community: However, even if the consumers themselves cannot use the Internet to access information, someone who is helping them access services may well have those skills. So providing reliable, useful information that helps the general population understand mental illness, its treatment, and that enhances recovery is valuable even to those consumers who do not have computer access themselves.

The consumers point this out in their discussions of problems and needs.

"Services are available but not known (about)."

"Better communication. Attempting to educate the general population about the services available."

Consumer Voice: Consumers and their families need to be deeply involved in the design and user specifications for this website. *They are the customers,* and that is how they must be treated.

POLICIES	GAPS AND NEEDS	JUSTIFICATION
At present, there is no policy about Internet health and mental health information, particularly across agencies – though it may also be implied in SHB 5273.	NEED: A policy directive to develop a mental health website across programs, assigning lead and cooperation responsibilities. Focus here would be developing content that helps to empower consumers, their families and their providers.	There is presently no single source of information that explains the state government mental health help available.

PRACTICES	GAPS AND NEEDS	JUSTIFICATION
Right now the MHD and the Mental Health Transformation both have websites. The MHT is about its processes; the MHD is about their program responsibilities. There is little about mental health specifically on the other program websites involved in providing services.	NEED: Cross agency information – providing a path through the maze for consumers and families. Should include local providers – who are they; what can they do? NEEDS: It might be useful to have some simple self-administered screening tests for depression, anxiety, bipolar, ADD, etc on this site.	Empowerment. Consumer Choice. Improve Access.

TRAINING	GAPS AND NEEDS	JUSTIFICATION
No single source of information on mental health training for consumers or for providers. No coordinated curriculum either.	NEEDS: Training for consumers and families? NEEDS: Training resources for providers on EBPs? Where and who? Links to the WorkShop Calendar and other training websites?	Chapters 3 and 4 spoke eloquently to this felt need on the part of consumers. Chapter 5 spoke to provider training needs.

ORGANIZATION	GAPS AND NEEDS	JUSTIFICATION
No one group is responsible – so no one is. Consumers should decide what information they want to know about. The state agencies, however, have to get the information, make sure it is accurate, and make it available to the website.	NEEDS: A lead organization, and a workgroup.	Someone needs to organize it.

CONSUMER VOICE	GAPS AND NEEDS	JUSTIFICATION
If this website is to be useful to consumers, they need to decide what sorts of information are most important to them.	NEEDS: Consumer and family guidance on the content needed on the website. NEEDS: Consumer voice on the site. Needs Stories of recovery – maybe filmed interviews. These should be REAL.	Chapters 3 and 4.

BUDGET	GAPS AND NEEDS	JUSTIFICATION
There is no budget at present. This role can be filled by MHT at present, but eventually where does it live?	GAP: A permanent home for the website.	

DATA	GAPS AND NEEDS	JUSTIFICATION
Provider data is program specific, not general. Very difficult for consumers to locate care options.	NEED: A database on providers: who can do what? NEED: Depends on what layers are chosen.	

APPENDICES

Appendix A

In-Depth Interviews with Underserved Consumers:

Survey Instrument

Washington State Mental Health Transformation
Needs Assessment

In-Depth Interviews with Underserved Consumers

BASIC INTERVIEW STRUCTURE
QUESTIONS AND PROBES

INTRODUCTION

→ Spend at least 5 minutes getting to know the person. Create a relaxed, safe environment.

→ Encourage the person to share their personal story. Record as much of it as you can. Perhaps use this probe to begin: What is the nature of your personal experience with the Washington state mental health system?

→ Explain the Transformation Grant and the role of the Needs Assessment activities. Stress the importance of having their input. Ask for permission to continue.

→ Begin a discussion about the term "mental illness" before you ask the interview questions. Perhaps use this as an opener: *What words are used in your circle of friends for mental illness, or emotional trauma, or behavior control problems?*

THE FOLLOWING 10 MAIN QUESTIONS ARE THE INFORMATION WE WISH TO COLLECT. SECTION 1 IS SIX QUESTIONS RELATED TO THE GOALS IDENTIFIED BY THE NEW FREEDOM COMMISSION. SECTION 2 CONTAINS FOUR QUESTIONS THAT HAVE BEEN ASKED AROUND THE STATE IN CONNECTION WITH THE ENTIRE NEEDS ASSESSMENT PROJECT. UNDER EACH MAIN QUESTION, WE HAVE SAMPLE QUESTIONS THAT CAN BE USED TO PROBE.

SECTION 1 – QUESTIONS RELATED TO NEW FREEDOM COMMISSION GOALS

(*Goal 1. Residents of Washington State understand that mental health is essential to overall health.)*

"Stigma-Busting in Washington" How are we doing?

1. Are you aware of any activities in Washington that reduce stigma about seeking help for mental health? If not, what kind of things do you think should happen?
2. Do you (or your child) discuss mental health issues with your medical doctor?
3. When you make a new friend, how long do you wait to tell them you (or your child) have a mental health or behavior concern in your life?
4. Do you feel safe asking for help with emotional, behavior, or mental health problems?
5. How many times per week do you hear someone make an unkind remark about people with mental health issues?

(Goal 2. Mental health care is consumer and family driven.)

"Do we have choices and ownership in mental health care?"

1. Do you feel you have choices in seeking help? Explain.
2. How many different people or places are involved in your (or your child's) mental health care? Do they coordinate with each other or do they complicate your life?

3. Please tell me about experiences in your life when you felt empowered (or that you had choices).
4. What type of help would you like to be available in your area?

(*Goal 3. Disparities in mental health services are eliminated.)*

"In Washington state, are mental health services accessible for all citizens?"

1. Where do you seek help for family problems?
2. Have you (or your child) ever been refused help or services?
3. Do you have health insurance?
4. Are you a veteran or using military facilities?
5. Do you believe your family culture is respected and understood by the people who have provided mental health treatment to you and your family?
6. Do you know where to go when you (or your child) need help?

(*Goal 4. Early mental health screening, assessment, and referral to services are common practice.)*

"Do we know where to seek help and how long does it take to get that help?"

1. What would you do if you or a loved one felt so sad, that they couldn't enjoy anything?
2. How long does it take for someone to get a first appointment with a mental health provider or counselor in your local community?
3. Can you tell me about when you first realized you (or your child) had mental health concerns?
4. Is mental health screening available in your area? Do doctors or schools or health clinics ask clients about mental, emotional, or behavior concerns?

(Goal 5. Excellent mental health care is delivered and research is accelerated.)

"What level of quality is the mental health care in your local area?"

1. How would you rate the mental health care in your community or neighborhood?
2. If there was 1 thing about mental health care in your area that you could change immediately, what would it be?
3. Please give me your definition of "excellent mental health care."

"What is going on in mental health research and what effect has it had in your life?"

1. Do you have access to information about mental health research? If so, what has made the biggest impression on your (or your child's) personal experience?
2. If you had the opportunity to do research related to mental health care from a consumer's (or family member's) perspective, what would you like to study?

(Goal 6. Technology is used to access mental health care and information.)

"Is technology helpful for accessing mental health care information?"

1. Have you used technology to learn more about mental health care and what is available? If so, how? If not, why?
2. Where do you seek more information about mental health?
3. What type of information would you like to access about mental health?

AT THIS POINT IN THE INTERVIEW IT WOULD BE APPROPRIATE TO ASK THE PERSON IF THEY NEED A BREAK.

SECTION 2 – Questions Related To Statewide Needs Assessment Activities

(Within the Washington State mental health service structure, what, in your opinion, is working well?)

"What is working well?"

1. Please tell me about a positive experience with mental health care.
2. How would you rate the ease of access to mental health services if and when you first sought help?
3. Please name (2) group activities in your local community that help you (or your child) stay busy or connected to people.
4. How would you rate the process of finding help in your local community?
5. Any other things you would like to tell me about things that work well?

(Within the Washington State mental health service structure, what, in your opinion, is NOT working, creates barriers, or fails to provide quality service and support?)

"What is *not* working well?"

1. Please tell me about a negative experience with mental health care.
2. How would you describe the availability of mental health resources in your area?
3. Do you have choices of activities or treatments that help you feel better? Does anyone encourage you in your effort to have a good life (or create a good life for your child)?
4. Any other things you would like to tell me about things that do not work well?

(From your perspective, what would a transformed mental health system look like?)

"Describe a *transformed* mental health system. (Or what would better look like?)"

1. If the state of Washington made improvements to the mental health system in the next (12) months, what (2) things would be top priority?
2. Please tell me your ideas about what a better mental health system looks like.
3. What do you hope to see after 5 years of improvement projects?
4. What needs to happen in Washington State as a result of transformation grant activities (all these surveys and meetings?

(What outcomes would indicate the system has transformed/changed in positive ways?)

"How will we know when positive changes in the system have happened?"

1. What results should we see at the end of year 1?
2. How do we get the information to families and consumers about positive system changes?
3. What part of the system do you think needs changing first?

SECTION 3 – General Demographic Information

(Interviewer will emphasize that no names will be used in the final report, only general information)

Age
Gender
Geographic location of residence
Military?
Ethnicity

Appendix B

Telephone Survey of Consumers: Survey Instrument

LETTER REQUESTING PARTICIPATION IN SURVEY

The telephone survey was conducted by The Washington Institute, located in Tacoma, Washington. This letter was sent to 1,500 randomly selected individuals on April 19, 2006 in English and Spanish requesting for participation in the survey.

English Version

The Washington Institute
9601 Steilacoom Boulevard SW
Tacoma, Washington 98498-7213

WE NEED YOUR HELP!

April 19, 2006

«First_Name» «Last_Name»
«Address»
«City», «State» «Zip_Code»

(«AREA_CODE») «PHONE_NUMBER»

Researchers from the University of Washington have been asked by the Department of Social and Health Services to talk with you about the mental health services you have received. We would like to talk to you over the telephone.

The survey we are asking you to participate in is part of the Transformation Grant. The Transformation Grant was designed to transform Washington State's mental health system so that it is consumer and family driven. We want to interview you to better understand what this new system should look like as well as what about the current system has helped and/or hindered your recovery. Since we cannot talk with everyone who uses mental health services in Washington, we have selected a small group of people to talk to. Your name was chosen com

One of our telephone interview
yellow colored letter. That's ho
interviewer calls at an inconven
make a telephone interview diff
If the telephone number shown
below and give us your current
questions or comments. What y

You don't have to take part in the
participate, just call the number i
will happen to you if you decide
receive. You may also stop the in
answer.

The information you give us du
provider or anyone else by nam

Thanks for Your Help,

Dr. Bennie McBride
Project Director

Spanish Version

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

Mental Health Division ▪ PO BOX 45320 ▪ Olympia WA 98504-5320 ▪ FAX (306) 902-7691

¡NECESITAMOS SU AYUDA!

El Departamento de Servicios Sociales y de Salud ha requerido de los investigadores de la Universidad de Washington hablar con usted acerca de los servicios de salud mental que ha recibido. Nos gustaría hablar con usted via telefónica.

La encuesta en la que le pedimos que participe se llama "Transformation Grant." Esta beca ha sido diseñada para transformar el sistema de Salud Mental para que así el consumidor y su familia sean los que operen el sistema. Queremos entrevistarlo para comprender mejor lo que este nuevo sistema debe de ser y al mismo tiempo en lo que el sistema actual ha obstaculizado o ayudado a su recuperación de salud. Puesto que no podemos hablar con todas las personas que usan los servicios de salud mental en el estado de Washington hemos seleccionado a un grupo pequeño para hablar con el. Su nombre ha sido seleccionado completamente al azahar. La encuesta durará aproximadamente de 15 a 20 minutos.

Uno de nuestros entrevistadores lo llamara en las próximas semanas para recordarle que le enviamos una carta amarillo. Asi sabrá usted que es uno de nuestros entrevistadores que esta llamando. Si nuestro entrevistador lo llama a una hora inconveniente pídale que lo llame cuando sea conveniente para usted. Si usted esta en alguna forma incapacitado para hacer la entrevista telefónica, dígaselo al entrevistador y haremos lo posible para hacer otros arreglos. Si el teléfono que mostramos debajo de su nombre al otro lado no es el correcto, por favor llame al número gratis 866/538-7611. También puede hablar a este número si tiene preguntas o comentarios. Lo que usted diga es muy importante para todos nosotros.

Usted no tiene que participar en la encuesta, pero esperamos que si. Si no desea participar llame al número que está abajo y déselos a saber, o dígaselo al entrevistador cuando lo llame. No habra represalias si usted decide no participar. Seguirá recibiendo sus beneficios tal y como los recibe hoy. Tambien puede parar la entrevista si no quiere contestar cualquier pregunta que no le parezca.

La información que nos de durante la entrevista es confidencial y no sera compartida con los que le dan servicios o cualquier persona por nombre.

Gracias por su ayuda,

Dr. Bennie McBride
Project Director

ENGLISH ON REVERSE!

PID

Telephone Survey of Consumers

Hello, my name is [Interviewer Name] and I am calling from the University of Washington. May I please speak to [Consumer Name]?

The reason I am calling is we have been asked by the Department of Social and Health Services to talk with people about the mental health services they received. Your name was picked at random from a list of people who received mental health services within the last six months.

Q: LETTER

A yellow colored letter was mailed to you recently describing the study.
Do you remember receiving it?

1. Yes
2. No
3. Don't Know

INTERVIEWER: If NO or DON'T KNOW, say:
It was a brief letter to let people know that we would be calling.
It was sent just recently and may not have arrived yet.

Q: EXPLAIN2

This telephone interview is completely voluntary. The information you provide will be confidential (private). Only the researchers at the University of Washington will see any information about you.
Information that could identify you will be destroyed. Your answers won't have anything to do with the services you or your family member have a right to receive. What you have to say is important to us and will be used to make mental health programs better.

Q: EXPLAIN3

The interview takes about 15 minutes. Do you have time to take the survey right now? For quality assurance, parts of this interview may be monitored by my supervisor. If I come to a question that you would prefer not to answer, just let me know and I will skip over it. If you don't understand a question or the meaning of a word, just ask me, OK?

1. Yes
2. No this is not a convenient time --->

   [INTERVIEWER, ASK: When would be a good time to call back?]
3. Unwilling to participate in the survey --->

   [INTERVIEWER: Thank respondent for their time.]

Q: EXPLAIN4

Great! To provide the best possible mental health services, we want to know what things helped or hindered your progress during the past six (6) months.

I am going to read you some statements.

After I read each statement, please tell me whether you:

- o Strongly Agree
- o Agree
- o Disagree
- o Strongly Disagree

If the statement is about something you did not experience, choose "Does not apply to me."

When you think about your experience, please choose the response that best represents your situation in the past six months. Okay?

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Does Not Apply To Me
1. I am encouraged to use consumer-run programs (for example: support groups, drop-in centers, etc.).	1	2	3	4	77	**88**
2. Staff respect me as a whole person.	1	2	3	4	77	**88**
3. There is at least one person who believes in me.	1	2	3	4	77	**88**
4. I do not have the support I need to function in the roles I want in my community.	1	2	3	4	77	**88**
5. I do not have enough good service options to choose from.	1	2	3	4	77	**88**
6. Mental health services helped me get housing in a place I feel safe.	1	2	3	4	77	**88**
7. Staff do not understand my experience as a person with mental health problems.	1	2	3	4	77	**88**
8. The mental health staff ignore my physical health.	1	2	3	4	77	**88**
9. I have a place to live that feels like a comfortable home to me.	1	2	3	4	77	**88**
10. Mental health services have caused me emotional or physical harm.	1	2	3	4	77	**88**
11. I cannot get the services I need when I need them.	1	2	3	4	77	**88**

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Does Not Apply To Me
12. Mental health services helped me get medical benefits that meet my needs.	1	2	3	4	77	**88**
13. Mental health services led me to be more dependent, not independent.	1	2	3	4	77	**88**
14. I lack the information or resources I need to uphold my client rights and basic human rights.	1	2	3	4	77	**88**
15. I have enough income to live on.	1	2	3	4	77	**88**
16. Services help me develop the skills I need.	1	2	3	4	77	**88**

Q: EXPLAIN5

Please listen to each of the following statements.

Consider the response that best represents your situation in the past six months.

After I read each statement, please tell me if it applies to you:

- o Always
- o Almost Always
- o Often
- o Sometimes
- o Rarely
- o Never

If the statement is about something you did not experience, choose "Does not apply to me."

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Does Not Apply To Me
17. I have a say in what happens to me when I am in crisis.	1	2	3	4	77	**88**
18. Staff believe that I can grow, change and recover.	1	2	3	4	77	**88**
19. I have housing that I can afford.	1	2	3	4	77	**88**
20. Staff use pressure, threats, or force in my treatment.	1	2	3	4	77	**88**
21. Staff see me as an equal partner in my treatment program.	1	2	3	4	77	**88**
22. Mental health staff support my self-care or wellness.	1	2	3	4	77	**88**

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	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Does Not Apply To Me
23. Mental health services helped me get or keep employment.	1	2	3	4	77	**88**
24. I have a chance to advance my education if I want to.	1	2	3	4	77	**88**
25. I have reliable transportation to get where I need to go.	1	2	3	4	77	**88**
26. There was a consumer peer advocate to turn to when I needed one.	1	2	3	4	77	**88**
27. There are consumers working as paid employees in the mental health agency (service agency) where I receive services.	1	2	3	4	77	**88**
28. Staff give me complete information in words I understand before I consent to treatment or medication.	1	2	3	4	77	**88**
29. Staff encourage me to do things that are meaningful to me.	1	2	3	4	77	**88**
30. Staff stood up for me to get the services and resources I needed.	1	2	3	4	77	**88**
31. Staff treat me with respect regarding my cultural background (think of race, ethnicity, religion, language, age, sexual orientation, etc.).	1	2	3	4	77	**88**
32. Staff listen carefully to what I say.	1	2	3	4	77	**88**
33. Staff lack up-to-date knowledge on the most effective treatments.	1	2	3	4	77	**88**
34. Mental health staff interfere with my personal relationships.	1	2	3	4	77	**88**
35. Mental health staff help me build on my strengths.	1	2	3	4	77	**88**
36. My right to refuse treatment is respected.	1	2	3	4	77	**88**
37. My treatment plan goals are stated in my own words.	1	2	3	4	77	**88**
38. The doctor worked with me to get on medications that were most helpful for me.	1	2	3	4	77	**88**
39. I am treated as a psychiatric label rather than as a person.	1	2	3	4	77	**88**

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	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Does Not Apply To Me
40. I can see therapist when I need to.	1	2	3	4	77	**88**
41. My family gets the education or supports they need to be helpful to me.	1	2	3	4	77	**88**
42. I have information or guidance to get the services and support I need, both inside and outside my mental health agency (service agency).	1	2	3	4	77	**88**

Q: EXPLAIN6

The next few questions are open-ended and I will type out what you say.

For the first couple questions, I want you to tell me what has been most and least helpful about the mental health services you received.

43. What two things do you like the MOST about the mental health services you received?

What about the mental health system in your opinion is working well?

44. What two things do you like the LEAST about the mental health services you received?

What about the mental health system in your opinion is NOT working well?

Q: EXPLAIN7

Now I want to ask your opinion about how the mental health system ought to be changed to make it better.

45. If you were giving advice to the mental health decision-makers in Washington State, what two things would you tell them that they or staff could do to make your life better?

46. What would the ideal mental health system look like to you?

47. If the mental health system changed, how would you know that the system is moving in a positive direction?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Q: EXPLAIN8

Please listen to each of the following statements. Choose the response that best represents your situation in the last six months.

We are going to use the term 'mental illness' in the rest of this questionnaire, but please think of it as whatever you feel is the best term for it.

After I read each statement, please tell me whether you:

- o Strongly Agree
- o Agree
- o Disagree
- o Strongly Disagree

If the statement is about something you did not experience, choose "Does not apply to me."

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Does Not Apply To Me
48. People discriminate against me because I have a mental illness.	1	2	3	4	77	**88**
49. Others think I can't achieve much in life because I have a mental illness.	1	2	3	4	77	**88**
50. People ignore me or take me less seriously just because I have a mental illness.	1	2	3	4	77	**88**
51. People often patronize me, or treat me like a child, just because I have a mental illness.	1	2	3	4	77	**88**
52. Nobody would be interested in getting close to me because I have a mental illness.	1	2	3	4	77	**88**

Q: EXPLAIN9

Last, I have some questions about you. Please be assured that the responses you give to these questions will only be used when comparing the responses of all the people we interview, not to identify you specifically.

Your individual responses will be kept strictly confidential.

Q: GENDER

Are you:

1. Female
2. Male

99. Refused

Q: DOB

What is your birthdate?

MONTH	**DAY**	**YEAR**

Q: RACE

What is the race or ethnic group you most consider yourself to belong?

1. American Indian or Alaskan Native
2. Asian
3. Black or African American
4. Hispanic or Latino
5. Native Hawaiian or Pacific Islander
6. White
7. Other (What race/ethnicity?_____)

INTERVIEWER: PROVIDE CATEGORIES IF THE RESPONDENT NEEDS THEM. IF MORE THAN ONE, ASK WITH WHAT GROUP THE RESPONDENT IDENTIFIES THE MOST.

77. Don't Know
99. Refused

Q: MARITAL

Which best describes your marital status?

1. Single
2. Domestic Partnership
3. Married
4. Divorced
5. Separated
6. Widowed

77. Don’t Know
99. Refused

Q: LIVING

What is your current living situation?

1. Independently in your own house or apartment
2. In subsidized housing (HUD Section 8 - AKA Choice Vouchers, King Co. Housing Authority, etc.)
3. With one parent (including step parents)
4. With both parents (including step parents)
5. With another family member (not including parents)
6. Crisis shelter
7. Homeless shelter
8. Group home
9. Residential treatment center
10. Psychiatric Hospital
11. Local jail or detention facility
12. Homeless
13. State corrections facility
14. With spouse or domestic partner
15. With someone other than above
16. Other (What is you current living situation?)

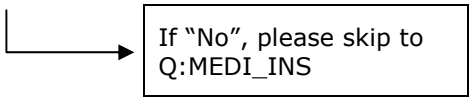
77. Don't Know
99. Refused

Q: EMPLOYED

Are you currently employed?

1. Yes
2. No

77. Don't Know
99. Refused



On average do you work:

1. More than 35 hours per week
2. Less than 35 hours per week

77. Don't Know
99. Refused

Q: BENEFITS

Do you receive benefits from your employer?

1. Yes
2. No

77. Don't Know
99. Refused

Q: EMP_BEN

Which of the following benefits do you receive from your employer? (Select all that apply)

1. None
2. Medical Insurance
3. Dental Insurance
4. Retirement
5. Disability Insurance
6. Paid Vacations/Sick Leave
7. Other (What other benefits do you receive?)

Q: MEDI_INS

Do you have Medicaid or Medicare Insurance?
(Circle all that apply)

1. None
2. Medicaid
3. Medicare Insurance
4. Medicare Part D
5. Healthcare for Workers with Disabilities (HWD)

77. Don't Know
99. Refused

YOU HAVE FINISHED THE SURVEY. THANK YOU VERY MUCH!

Q: LANGUAGE

What language was this interview completed in?

1 English
2 Spanish

Appendix C

Regional Support Network Interviews:

Survey Instrument

Washington State Mental Health Transformation
Needs Assessment

Regional Support Network Interviews

INTERVIEW STRUCTURE

(See following pages for mailing distributed prior to interview)

START

- ☐ Discuss cover sheet
- ☐ Cover six Freedom Goals
- ☐ Cover timeline
- ☐ Ask for innovative providers:

1. Children: _____
2. Adults: _____
3. Elderly: _____
4. Others: (ALL) _____

DISCUSS RSN PERSPECTIVE ABOUT MENTAL HEALTH SERVICES

1. What is working well at your RSN at this time?

2. What is not working for your RSN at this time?

3. What would a 'Transformed MH system look like?

4. What changes would you make to your system? With modest new funding:

ATTACHMENT

A

The Goals & Planning Process

TRANSFORMATION

RESOURCE INVENTORY & NEEDS ASSESSMENT

WASHINGTON STATE MENTAL HEALTH

Topics to cover

PREPARED FOR

Regional Support Networks

The Freedom Goals

The President's *New Freedom Commission on Mental Health* identifies six "Freedom Goals" that must be met by Mental Health Transformation Grant recipients:

- Americans understand that mental health is essential to overall health
- Mental health care is consumer and family driven
- Disparities (cultural & geographical) in mental health services are eliminated
- Early mental health screening, assessment, and referral to services are common practice
- Excellent mental health care is delivered and research is accelerated
- Technology is used to access mental health care and information

Keeping these goals in mind, the sample questions in this packet are provided to help you prepare for our upcoming telephone interview.

Planning Process and Due Dates

APRIL 21 2006 — **Subcommittee Reports to Transformation Work Group**

Based on Subcommittee Workgroup meetings and Public Hearings across the state.

TWG Subcommittees:

- Children/youth and parents/families
- Adult consumers and families
- Older adult consumers and families
- Transitioning populations and age groups
- Homeless population
- Criminal justice/mentally ill offender population
- People with co-occurring mental health and other disorders (dual diagnoses)

MAY 15 — **DRAFT Report on Resource Inventory and Needs Assessment** (to Transformation Workgroup – TWG)

Based on surveys of:

- State agencies or programs
- Providers
- Consumers
- Public hearings
- In-depth interviews

JUNE 15 — **FINAL Report on Resource Inventory and Needs Assessment** (to SAMHSA)

AUGUST 1 — **DRAFT State Plan** (TWG)

SEPTEMBER 30 — **FINAL Plan** (to SAMHSA)

March 15, 2006

Washington State Department of Social & Health Services

1

ATTACHMENT

A

FOR

RSN Director Interview

Topics to cover

PREPARED FOR

Regional Support Networks

Key Provider Contacts

It is especially important that we are able to contact providers by email, because we are asking them to share their information and innovations in a written survey that will be sent by email soon.

Please help us by identifying key providers in your RSN that are representative of what mental health services are provided to the following consumers:

NOTE: Not all boxes need to be completed; some providers may serve more than one type of consumer.

Children

	PROVIDER NAME	PHONE	EMAIL ADDRESS @
1			

Adults

	PROVIDER NAME	PHONE	EMAIL ADDRESS @
2			

Elderly

	PROVIDER NAME	PHONE	EMAIL ADDRESS @
3			

Please help us by identifying one provider who exemplifies innovative practices in your RSN:

More Innovative Provider

	PROVIDER NAME	PHONE	EMAIL ADDRESS @
4			

Innovative practices: _____

March 15, 2006

Washington State Department of Social & Health Services

2

ATTACHMENT

B

FOR

RSN Director Interview

TRANSFORMATION

RESOURCE INVENTORY & NEEDS ASSESSMENT

WASHINGTON STATE MENTAL HEALTH

Topics to cover

PREPARED FOR

Regional Support Networks

Your individual responses will become part of a larger group of responses from a variety of perspectives

March 15, 2006

Washington State Department of Social & Health Services

3

Please Help Us Identify Unmet Mental Health Need

The federal grant requires a broad definition of mental health disorders that affect functioning in daily life.

These range from mild mental health disorders to severe and persistent mental illness, including:

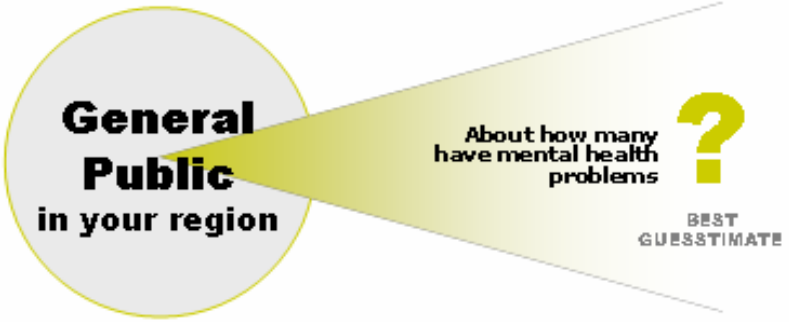
- Thought disorders like schizophrenia, paranoia, multiple personality
- Mood disorders like depression, anxiety, bi-polar, phobias, suicidal ideas
- Personality disorders like ADHD, borderline personality, aggressive
- Childhood personality diagnoses such as oppositional defiant disorder
- Family problems, parenting problems
- Senility

These disorders may affect consumers' functioning in daily life and their ability to participate in the services provided by other DSHS programs or other agencies.

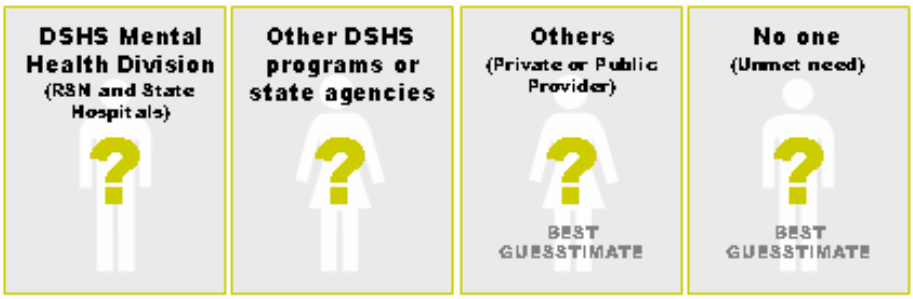
DSHS often serves sub-populations that are more likely to experience mental health disorders than the general population.

Given lack of uniform screening and data collection, when we arrive for the interview, we'll be asking for some best "guesstimates."

- ***Can you guess the extent to which persons in your region may have mental health disorders that affect their daily life?***



- ***How many receive mental health services from ... ?***



- ***Are people not getting needed mental health services due to cultural or geographic barriers in your region?***
- ***From your perspective, what is the impact of <u>not</u> providing needed mental health services?***

ATTACHMENT

B

FOR

RSN Director Interview

Topics to cover

PREPARED FOR

Regional Support Networks

Tell us about your RSNs perspective about mental health services in general:

What's working for you now?

Across all state-funded mental health services

In your RSN

What's NOT working?

Across all state-funded mental health services

In your RSN

What would a "transformed" mental health system look like?

Across all state-funded mental health services

How would it impact your RSN organization?

What changes would you make to the system?

Within current constraints

With modest new funding

What changes would you expect to see in the lives of mental health consumers if system transformations were implemented?

What outcomes would improve . . .

- for consumers in your region?
- for your RSN organization?

Your individual responses will become part of a larger group of responses from a variety of perspectives

March 15, 2006

Washington State Department of Social & Health Services

d

ATTACHMENT

B

FOR

RSN Director Interview

TRANSFORMATION

RESOURCE INVENTORY & NEEDS ASSESSMENT

WASHINGTON STATE MENTAL HEALTH

Topics to cover

PREPARED FOR

Regional Support Networks

Your individual responses will become part of a larger group of responses from a variety of perspectives

March 15, 2006

Washington State Department of Social & Health Services

5

Tell us what practices you have already implemented in your region to move toward a mental health system that better meets the needs of your consumers?

Practice 1

1

Practice 2

2

Practice 3

3

Practice 4

4

Practice 5

5

ATTACHMENT

B

FOR

RSN Director Interview

TRANSFORMATION

RESOURCE INVENTORY & NEEDS ASSESSMENT

WASHINGTON STATE MENTAL HEALTH

Topics to cover

PREPARED FOR

Regional Support Networks

Your individual responses will become part of a larger group of responses from a variety of perspectives

March 15, 2006

Washington State Department of Social & Health Services

6

Tell us what other major changes would need to occur in the following areas to implement a "transformed" system:

Services

Across all state-funded mental health services

In your RSN

Organization

Across all state-funded mental health services

In your RSN

Policies

Across all state-funded mental health services

In your RSN

Training

Across all state-funded mental health services

In your RSN

Client Involvement

Across all state-funded mental health services

In your RSN

How do the President's Six "Freedom Goals" relate to the changes you suggested?

	LOTS	SOME	NONE	n/a
Less stigma				
More consumer driven				
Less disparities				
More early screening				
Better services				
More use of technology				

Appendix D

Questions Asked of Top Executives:

Survey Instrument

Questions Asked of Top Executives

Key Questions

1. Do some of your clients have mental and behavioral health problems that cause them problems in their daily life and in your program?
   - ❑ Yes (continue)
   - ❑ NO (skip to Q5)
   - ❑ Don't know (skip to q5)

2. What sorts of mental health problems do they have? (please check all that apply)
   - ❑ Mood disorders like depression, anxiety, bi-polar, phobias, suicidal ideas
   - ❑ Thought disorders like schizophrenia, paranoia, multiple personality
   - ❑ Personality disorders like ADHD, borderline personality, aggressive
   - ❑ Childhood personality diagnoses such as oppositional defiant disorder
   - ❑ Family problems, parenting problems
   - ❑ Other (please define) _____

3. **Data:** Are these client mental health problems recorded in your client data systems?
   - ❑ Yes (continue)
   - ❑ NO (skip to Q5)
   - ❑ Don't know (skip to q5)

4. **HQ Data Contact:** Who would be a good contact to discuss that data system?

5. Does your program provide or fund any mental health treatment for your clients?
   - ❑ NO (skip to Q 9)
   - ❑ YES (continue)

6. What type of mental health treatment does your program provide or fund? (please check all that apply)
   - ❑ Counseling
   - ❑ Residential treatment with counseling
   - ❑ Medication
   - ❑ Assessment
   - ❑ Diagnosis
   - ❑ Other (please describe)

7. **HQ Service Contacts:** We need to ask some detailed questions the policies, practices, providers and eligibility for about those treatments. Who on your staff would be a good person to talk to about the operation of those treatments?

8. **Mental Health Funding Contact:** Who on your staff would be a good person to talk to about the budget and expenditures on those treatments?

THESE NEXT QUESTIONS DEAL WITH WHETHER THE MENTAL HEALTH NEEDS OF YOUR CLIENTS ARE BEING MET.

9. About how many of your clients with mental health problems receive mental health treatment or benefits from your program?
   - ❑ Most
   - ❑ About half
   - ❑ Few or none
   - ❑ I really don't have any idea.

10. About how many of your clients receive mental health services from someone else – not your program, and not the mental health division? (For example, through their pastor, or their doctor?)
    - ❑ Most
    - ❑ About half
    - ❑ Few or none
    - ❑ I really don't have any idea.

11. About what proportion of your clients with mental health problems receive mental health treatment from the Mental Health Division (through the RSN or the state hospitals or child study and treatment center) while they are your clients?
    - ❑ Most
    - ❑ About half
    - ❑ Few or none
    - ❑ I really don't have any idea.

12. Are there mental health services needed by your clients that are not provided anywhere? If yes, what is the nature of those missing services?

13. Can you give your ideas about the impact of not providing those services?

THESE NEXT QUESTIONS ASK WHAT YOU THINK ABOUT WASHINGTON'S SYSTEM OF MENTAL HEALTH CARE.

14. For your clients, what seems to be working in Washington's system of state-subsidized mental health care?

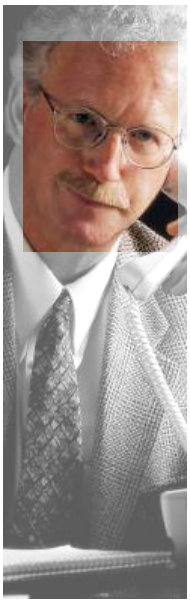
15. For your clients, what doesn't seem to be working?

16. Are there geographic, cultural, demographic or other subgroup (such as homeless, prisoners, young single adults) who are not getting good access, in the current system of mental health care?

17. If you were a benevolent dictator, what sorts of changes would you make in the system of state-subsidized mental health care? Assume only a modest amount of new money; what would be at least three important changes to make (more than three is okay!)?

18. What changes would you expect to see in the lives of your clients, if those system improvement changes were implemented?

THANK YOU VERY MUCH FOR YOUR TIME AND THOUGHT!



Appendix E

Questions Asked of Middle Managers:

Survey Instrument

Questions Asked of Middle Management

Questions About Agency-Wide Mental Health Services

Policies and Training

1. POLICIES

Policies include WACs, in-agency policies, agency "traditions," training manuals, academy directives.

- What people are eligible for mental health services, per policy?
- What policies require mental health services be offered?
- What policies prevent needed mental health services from being offered?
- What exceptions, if any, are made to policy to accommodate clients with mental health disorders?

2. TRAINING

- What credentials do employees have when they are hired?
- Academies (how often, who participates)?
- Other training (how often, who participates)?
- Can employees request non-standard training?

3. CUSTOMER INVOLVEMENT

- Do consumers help set agency policies?
- Are they trained to do this?

Individual Practices

1. CONTENT OF SERVICES

- Describe the service
- Does the service include recovery support?
- Is it an evidence-based practice?

2. FACILITIES AND EQUIPMENT

- Where is service provided?
- Beds/slots?
- Staff?
- Contractors?
- Caseloads?

3. ORGANIZATION/COLLABORATIONS

- Staff?
- Contract hire?
- Staff that are (were) consumers?
- Persons served per fiscal year?

- Capacity x average length of stay?
- Required collaborations?
- Non-required collaborations?

4. CONSUMER INVOLVEMENT

- Consumer (and consumer family) voice?
- Tailored services?
- Choice of provider?
- Feedback solicited?
- Feedback used?
- Consumers on staff?

Funding and Data

1. WHAT DATA RELATED TO MENTAL HEALTH SERVICES ARE COLLECTED?

- Screening/assessment

A. Who enters these data?	
B. How often are these records entered?	
B.1 Upon receiving treatment or services?	
B.2 Periodically (monthly for billing)?	
B.3 At the end of expected course of services?	
C. What is the form of the data?	
C.1 Service codes, dates and/or frequency?	
C.2 Service descriptor, dates and/or frequency?	

- Services

A. Who enters these data?	
B. How often are these records entered?	
B.1 Upon receiving treatment or services?	
B.2 Periodically (monthly for billing)?	
B.3 At the end of expected course of services?	
C. What is the form of the data?	
C.1 Service codes, dates and/or frequency?	
C.2 Service descriptor, dates and/or frequency?	

- Medication management (maintain lists of meds for each person?)

A. Who enters these data?	
B. How often are these records entered?	
B.1 Upon receiving treatment or services?	
B.2 Periodically (monthly for billing)?	
B.3 At the end of expected course of services?	

C. What is the form of the data?	
C.1 Service codes, dates and/or frequency?	
C.2 Service descriptor, dates and/or frequency?	

- Recovery support

A. Who enters these data?	
B. How often are these records entered?	
B.1 Upon receiving treatment or services?	
B.2 Periodically (monthly for billing)?	
B.3 At the end of expected course of services?	
C. What is the form of the data?	
C.1 Service codes, dates and/or frequency?	
C.2 Service descriptor, dates and/or frequency?	

- Follow-up – tracking of outcomes of consumers who have used your services

A. Who enters these data?	
B. How often are these records entered?	
B.1 Upon receiving treatment or services?	
B.2 Periodically (monthly for billing)?	
B.3 At the end of expected course of services?	
C. What is the form of the data?	
C.1 Service codes, dates and/or frequency?	
C.2 Service descriptor, dates and/or frequency?	

EFFORTS TO PROMOTE MENTAL HEALTH (PREVENTION)

- Universal Populations
- Selected Populations
- Indicated Populations

AGENCY BUDGET FOR MH SERVICES

1. How is the mental health services budget divided?

☐ Federal – Medicaid (estimated percentage): _____
☐ Federal – Grant (estimated percentage): _____
☐ State General Fund (estimated percentage): _____

2. What is the mental health cost per person served?

3. Are there other sources of funding besides those mentioned in Question 1?

- ☐ Sliding Fees _____
- ☐ Private Insurance _____
- ☐ County/City _____
- ☐ Private Pay _____

4. What is the mental health cost per person served?

Estimation of the non-required, but necessary, mental health services costs

Agency services that are mental health related (estimated percentage):		**%**
Clients using services who have mental health issues (estimated percentage):		**%**

Suggested Changes

Please let us explain a bit about the President's six "Freedom Goals."

Now, consider the information you have shared about the ways in which your agency serves clients with mental health disorders.

In your opinion, what two or three changes in (pick one: programming, data collection, financial management) would have the greatest positive impact on those clients?

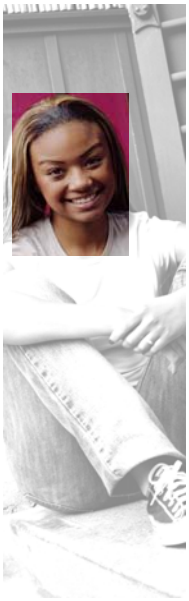
PROGRAMMING
DATA COLLECTION
FINANCIAL MANAGEMENT

How would the changes you suggested affect the following areas?

- Service provision (inside/outside agency)?
- Organization (inside/outside agency)?
- Policies (inside/outside agency)?
- Training (inside/outside agency)?
- Client involvement (inside/outside agency)?
- Data Collection
- Financial Management (Budget)

Returning to the "Freedom Goals," how much would the changes you suggested affect the following areas (lots, some, none, or n/a)?

- Less stigma
- More consumer driven
- Less disparities
- More early screening
- Better services
- More use of technology



Appendix F

Supporting Tables:

Annual RSN Data

RSN Consumer Counts and Expenditures, FY 2004

Supplemental Detail for Chapter 5

Data provided by DSHS Research and Data Analysis Division

NOTE: The tables below and on the facing page show FY 2004 treatment modalities and expenditures for clients living within RSN boundary areas (RSN of service has been imputed from the client's county of residence). All state hospital and most community psychiatric inpatient services are not included in the table.

Number of Consumers Served by Modality

By Regional Support Network, FY 2004

Continued on facing page

Modality	Chelan-Douglas	Clark	Cowlitz	Grays Harbor	Greater Columbia	King
Crisis Services	655	2,007	1,362	627	5,131	9,672
Day Support	1	150	17	0	363	1,710
Family Treatment	332	1,636	327	460	1,759	7,929
Freestanding Evaluation & Treatment	5	0	2	11	10	759
Group Treatment Service	171	455	136	57	1,960	3,981
High Intensity Treatment	91	286	117	3	132	98
Individual Treatment	2,066	4,773	3,874	1,729	13,813	27,981
Intake Evaluation	1,178	3,276	1,727	1,240	8,850	13,645
Medication Management	373	1,531	865	412	7,417	11,194
Medication Monitoring	461	2,640	337	487	2,058	3,510
Mental Health Residential Treatment	2	32	1	9	57	662
Peer Support	98	3	20	2	11	1,225
Psychological Assessment	5	38	20	0	86	79
Rehabilitation Case Management	8	3	5	1	265	932
Stabilization Services	44	133	10	91	79	244
Therapeutic Psychoeducation	272	2	6	0	600	10
Non-State Plan Services	62	103	104	62	164	5,318
Respite Services(B3)	0	0	10	3	18	575
Supported Employment (B3)	0	152	151	48	31	422
Clubhouse (B3)	0	0	43	0	39	80
TOTAL	**2,476**	**6,837**	**4,446**	**2,349**	**18,666**	**34,899**

State Plan Modality Service Expenditures

By Regional Support Network, FY 2004

Continued on facing page

Modality	Chelan-Douglas	Clark	Cowlitz	Grays Harbor	Greater Columbia	King
Crisis Services	$649,187	$1,833,959	$339,959	$154,682	$1,202,209	$20,050,187
Day Support	$69	$596,059	$843	$0	$4,321,346	$12,035,053
Family Treatment	$107,789	$842,937	$80,399	$140,241	$545,905	$2,229,792
Freestanding Evaluation & Treatment	$31,856	$0	$40,218	$36,236	$67,694	$5,456,916
Group Treatment Service	$132,565	$259,382	$114,965	$19,185	$3,335,922	$7,653,162
High Intensity Treatment	$33,872	$183,045	$48,809	$173	$35,629	$1,165,507
Individual Treatment	$1,703,911	$5,878,991	$3,166,940	$1,158,632	$9,722,480	$28,178,779
Intake Evaluation	$152,992	$405,706	$199,640	$137,498	$1,045,506	$1,795,543
Medication Management	$38,164	$103,078	$158,297	$38,026	$1,204,276	$1,728,689
Medication Monitoring	$97,316	$482,431	$164,950	$66,197	$94,519	$425,108
Mental Health Residential Treatment	$2,461	$335,415	$123	$64,597	$11,687	$12,418,963
Peer Support	$206,947	$1,691	$487,488	$2,358	$11,338	$3,848,595
Psychological Assessment	$385	$5,890	$18,880	$0	$8,397	$24,344
Rehabilitation Case Management	$1,651	$196	$1,599	$173	$59,082	$113,908
Stabilization Services	$485,714	$180,757	$3,015	$835,798	$107,813	$2,026,182
Therapeutic Psychoeducation	$27,982	$242	$1,340	$0	$55,089	$983
Non-State Plan Services	$4,210	$3,141,275	$14,267	$390,043	$10,520	$457,777
Respite Services(B3)	$0	$0	$2,251	$788	$12,306	$435,051
Supported Employment (B3)	$0	$76,316	$50,906	$16,870	$32,903	$355,438
Clubhouse (B3)	$0	$0	$250,555	$0	$236,507	$50,740
TOTAL	**$7,753,653**	**$20,495,749**	**$8,949,074**	**$5,499,736**	**$38,805,913**	**$150,256,136**

Table continued from facing page

North Central	North Eastern	North Sound	Peninsula	Pierce	Spokane	Thurston-Mason	Timberlands
823	219	6,619	2,692	7,877	2,705	1,778	1,000
0	4	158	431	37	260	45	47
100	127	1,254	774	2,572	1,613	504	353
0	1	542	377	62	7	12	7
266	206	2,606	1,121	1,541	1,522	799	203
2	0	4	94	76	27	10	56
2,690	1,424	12,702	5,919	10,558	8,295	4,244	2,811
1,234	748	7,442	2,815	4,960	4,505	2,736	1,571
340	357	5,145	2,536	4,640	3,909	1,869	668
402	81	53	13	97	34	470	1,089
0	2	221	216	104	296	17	1
2	30	16	1	19	7	6	69
0	1	0	0	5	178	2	0
17	2	838	112	30	13	16	3
4	4	648	232	41	210	210	61
114	10	5	1	7	246	85	15
107	0	66	44	42	33	35	501
2	0	51	0	3	42	11	10
35	0	6	160	18	1	49	177
0	1	1	0	0	262	1	32
3,011	**1,684**	**18,043**	**7,515**	**15,854**	**10,433**	**5,721**	**3,974**

Table continued from facing page

North Central	North Eastern	North Sound	Peninsula	Pierce	Spokane	Thurston-Mason	Timberlands
$177,523	$151,751	$2,958,340	$1,580,867	$8,148,405	$2,392,404	$399,965	$321,758
$0	$24,091	$654,237	$4,611,668	$209,397	$3,462,877	$115,300	$36,010
$21,460	$27,469	$408,983	$305,591	$1,534,721	$601,508	$159,034	$157,326
$0	$32,254	$6,086,463	$3,216,248	$393,420	$27,874	$70,481	$35,440
$428,336	$212,410	$2,945,189	$1,931,294	$2,540,983	$2,408,361	$709,961	$129,060
$1,245	$0	$3,854	$176,752	$1,313,511	$15,564	$5,908	$22,159
$1,553,876	$1,343,354	$8,609,916	$4,532,894	$10,500,707	$8,240,323	$3,372,662	$4,000,971
$144,481	$88,310	$753,273	$325,066	$548,778	$720,655	$383,268	$220,208
$24,717	$31,324	$847,440	$525,350	$833,420	$719,333	$340,725	$56,975
$41,884	$4,098	$4,304	$1,760	$9,366	$4,323	$31,489	$327,454
$0	$11,689	$4,995,783	$927,129	$1,361,839	$5,162,883	$201,543	$1,477
$161	$64,712	$8,868	$2,692	$11,747	$5,603	$3,567	$83,140
$0	$92	$0	$0	$1,847	$79,089	$609	$0
$1,461	$1,168	$288,722	$7,046	$5,839	$3,923	$3,599	$823
$22,911	$14,805	$3,305,151	$4,647,925	$258,740	$858,843	$1,450,015	$914,061
$4,379	$9,819	$380	$35	$1,387	$552,212	$25,241	$1,932
$5,611	$0	$6,292	$2,508	$121,222	$2,504	$16,598	$344,369
$518	$0	$173,713	$0	$6,234	$25,098	$11,639	$1,018
$38,225	$0	$587	$55,849	$3,273	$846	$15,078	$136,982
$0	$1,243	$1,898	$0	$0	$2,484,970	$17	$6,115
$6,942,769	**$4,629,236**	**$52,701,096**	**$28,638,676**	**$99,834,691**	**$61,728,113**	**$14,396,096**	**$9,117,552**

Appendix G

Agency Staff Interviews:
Acknowledgements

Acknowledgements of Agency Respondents

We wish to thank the following agency participants for assisting with the Resource Inventory and Needs Assessment by so generously providing their information, time, and insight on behalf of Washington State's Mental Health Transformation effort.

Traci Adair	DSHS, Aging and Disability Services Administration
Doug Allen	DSHS, Health and Recovery Services Administration, Division of Alcohol and Substance Abuse
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Julie Baker	Community, Trade and Economic Development, Community Services Division
Chuck Benjamin	North Sound Regional Support Network
Ron Blake	Southwest Regional Support Network
Kelly Boston	DSHS, Vocational Rehabilitation
Ken Brown	DSHS, Juvenile Rehabilitation Administration
Kay Christenson	DSHS, Economic Services Administration, Community Services Division
John Clayton	DSHS, Economic Services Administration, Community Services Division
Chris Coleman	DSHS, Aging and Disability Services Administration, Divison of Developmental Disabilities
Jim Colvin	Chelan-Douglas Counties Regional Support Network
Annie Conant	Community, Trade and Economic Development, Housing Division
Stephanie Condon	Community, Trade and Economic Development, Community Services Division, Office of Crime Victims Advocacy
Mark Dalton	DSHS, Economic Services Administration, Community Services Division
Cheri Dolezal	Clark County Regional Support Network
Anders Edgerton	Peninsula Regional Support Network
Kelly Egan	Department of Corrections
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Mark Freedman	Thurston-Mason Regional Support Network
Rosa Giberson	DSHS, Economic Services Administration, Community Services Division
Will Graham	Community, Trade and Economic Development, Community Services Division, Long Term Care Ombudsman
Wendi Gunther	DSHS, Health and Recovery Services Administration, Mental Health Division
Dave Guthmann	DSHS, Juvenile Rehabilitation Administration
Judy Hall	DSHS, Health and Recovery Services Administration, Mental Health Division
Bill Hardy	North Central Regional Support Network
Patty Hayes	Washington State Department of Health
Tory Henderson	Washington State Department of Health, Community and Family Health

Ron Hertel	Office of Superintendent of Public Instruction
Theresa Hilliard	Department of Corrections
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Jacalyn Hurn	North Eastern Regional Support Network
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Jon Ihli	DSHS, Adult and Disability Services Administration, Home and Community Services
Gaye Jensen	DSHS, Juvenile Rehabilitation Administration
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Mona Johnson	Office of Superintendent of Public Instruction
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Rebecca Kelly	DSHS, Juvenile Rehabilitation Administration
Judy King	Community, Trade and Economic Development, Community Services Division
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Glenn Lippman	Greater Columbia Regional Support Network
Logan MacGregor	Community, Trade and Economic Development, Community Services Division
Christina Maleney	Department of Corrections
Kent Meneghin	Community, Trade and Economic Development, Community Services Division
Bill Moss	DSHS, Adult and Disability Services Administration, Home and Community Services
Martin Mueller	Office of Superintendent of Public Instruction
Patricia Noble-Desy	Department of Corrections
Marijo Olson	Community, Trade and Economic Development, Community Services Division
Toby Olson	Employment Security Department
Cathie Ott	DSHS, Health and Recovery Services Administration, Medical Assistance

Larita Paulsen	DSHS, Adult and Disability Services Administration, Home and Community Services
Harvey Perez	DSHS, Health and Recovery Services Administration, Division of Alcohol and Substance Abuse
Doug Porter	DSHS, Health and Recovery Services Administration, Medical Assistance
Laura Porter	Family Policy Council
Stephanie Pratt	Community, Trade and Economic Development, Community Services Division, Office of Crime Victims Advocacy
Barb Putnam	DSHS, Children's Administration
Pam Raymond	DSHS, Economic Services Administration, Community Services Division
Edie Rice-Sauer	Spokane County Regional Support Network
Patricia Richards	DSHS, Adult and Disability Services Administration, Division of Developmental Disabilities
Marcia Riggers	Office of Superintendent of Public Instruction
Jean Robertson	King County Regional Support Network
Ann Rockway	Timberlands Regional Support Network
Linda Rolfe	DSHS, Adult and Disability Services Administration, Division of Developmental Disabilities
Lynnae Ruttledge	DSHS, Director, Vocational Rehabilitation
Tom Saltrup	Department of Corrections
Robert Schaffer	DSHS, Adult and Disability Services Administration, Division of Developmental Disabilities
Tom Schumacher	Washington State Department of Veterans Affairs
Doug Sevin	Community, Trade and Economic Development, Community Services Division
Sekou Shabaka	DSHS, Assistant, Secretary, Juvenile Rehabilitation Administration
Lynne Shanafelt	Community Trade and Economic Development, Community Services Division
Joan Sharp	Washington Council for Prevention of Child Abuse and Neglect
Katrina Wynkoop Simmons	Washington State Department of Health
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Cheryl Strange	DSHS, Adult and Disability Services Administration, Division of Developmental Disabilities
John Taylor	DSHS, Health and Recovery Services Administration, Division of Alcohol and Substance Abuse
Richard Torrance	Community, Trade and Economic Development, Community Services Division
Mark Westenhaver	DSHS, Economic Services Administration, Community Services Division
David Weston	DSHS, Health and Recovery Services Administration, Mental Health Division
Ted Wilson	Department of Corrections
Chris Winans	DSHS, Health and Recovery Services Administration, Mental Health Division
Fritz Wrede	DSHS, Health and Recovery Services Administration, Division of Alcohol and Substance Abuse